Chapter 17

Transition to Parenthood

BARBRA MANNING

LEARNING OBJECTIVES

- Discuss ways to facilitate parent-infant adjustment.
- Describe sensual responses that strengthen attachment.
- Identify infant behaviors that facilitate and inhibit parental attachment.
- Differentiate three periods in parental role change after childbirth.
- Explain behaviors of the three phases of maternal adjustment.
- Discuss paternal adjustment.
- Examine the effects of the following on parental response: parental age (adolescence and over 35 years), culture, socioeconomic conditions, personal aspirations, and sensory impairment.
- Describe sibling adjustment.
- Explain grandparent adaptation.

KEY TERMS AND DEFINITIONS

acquaintance  Process used by parents to get to know or become familiar with their new infant; an important step in attachment
attachment  A specific and enduring affective tie to another person
becoming a mother  Transformation and growth of the mother identity
biorythmicity  Cyclic changes that occur with established regularity, such as sleeping and eating patterns
bonding  A process by which parents, over time, form an emotional relationship with their infant
claiming process  Process by which the parents identify their new baby in terms of likeness to other family members, differences, and uniqueness
en face  Face-to-face position in which the parent’s and infant’s faces are approximately 20 cm apart and on the same plane
engrossment  A parent’s absorption, preoccupation, and interest in his or her infant; term typically used to describe the father’s intense involvement with his newborn
entrainment  Phenomenon observed in the microanalysis of sound films in which the speaker moves several parts of the body and the listener responds to the sounds by moving in ways that are coordinated with the rhythm of the sounds (infants have been observed to move in time to the rhythms of adult speech but not to random noises or disconnected words or vowels); believed to be an essential factor in the process of maternal-infant bonding
letting-go phase  Interdependent phase after birth in which the mother and family move forward as a system with interacting members
mutuality  Parent-infant interaction in which the infant’s behaviors and characteristics call forth a corresponding set of maternal behaviors and characteristics
postpartum blues  A let-down feeling, accompanied by irritability and anxiety, which usually begins 2 to 3 days after giving birth and disappears within a week or two; sometimes called “baby blues”
reciprocity  Type of body movement or behavior that provides the observer with cues, such as the behavioral cues infants provide to parents and parents’ responses to cues
sibling rivalry  A sibling’s jealousy of and resentment toward a new child in the family
synchrony  Fit between the infant’s cues and the parent’s response
taking-hold phase  Period after birth characterized by a woman becoming more independent and more interested in learning infant care skills; learning to be a competent mother is an important task
taking-in phase  Period after birth characterized by the woman’s dependency; maternal needs are dominant, and talking about the birth is an important task
transition to parenthood  Period of time from the preconception parenthood decision through the first months after birth of the baby during which parents define their parental roles and adjust to parenthood
Becoming a parent creates a period of change and instability for men and women who decide to have children. This occurs whether parenthood is biologic or adoptive and whether the parents are married husband-wife couples, cohabiting couples, single mothers, single fathers, lesbian couples with one woman as biologic mother, or gay male couples who adopt a child. Parenting may be described as a process of role attainment and role transition that begins during pregnancy. The transition ends when the parent develops a sense of comfort and confidence in performing the parental role.

**PARENTAL ATTACHMENT, BONDING, AND ACQUAINTANCE**

The process by which a parent comes to love and accept a child and a child comes to love and accept a parent is referred to as *attachment*. Using the terms *attachment* and *bonding*, Klaus and Kennell (1997) proposed that the period shortly after birth is important to mother-to-infant attachment. They defined the phenomenon of *bonding* as a sensitive period in the first minutes and hours after birth when mothers and fathers must have close contact with their infants for optimal later development (Klaus & Kennell, 1976). Klaus and Kennell (1982) later revised their theory of parent-infant bonding, modifying their claim of the critical nature of immediate contact with the infant after birth. They acknowledged the adaptability of human parents, stating that it took longer than minutes or hours for parents to form an emotional relationship with their infants. The terms *attachment* and *bonding* continue to be used interchangeably.

Attachment is developed and maintained by proximity and interaction with the infant, through which the parent becomes acquainted with the infant, identifies the infant as an individual, and claims the infant as a member of the family. Attachment is facilitated by positive feedback (i.e., social, verbal, and nonverbal responses, whether real or perceived, that indicate acceptance of one partner by the other). Attachment occurs through a mutually satisfying experience. A mother commented on her son’s grasp reflex, “I put my finger in his hand, and he grabbed right on. It is just a reflex, I know, but it felt good anyway” (Fig. 17-1).

The concept of attachment has been extended to include *mutuality*; that is, the infant’s behaviors and characteristics call forth a corresponding set of parental behaviors and characteristics. The infant displays signaling behaviors such as crying, smiling, and cooing that initiate the contact and bring the caregiver to the child. These behaviors are followed by executive behaviors such as rooting, grasping, and postural adjustments that maintain the contact. The caregiver is attracted to an alert, responsive, cuddly infant and repelled by an irritable, apparently disinterested infant. Attachment occurs more readily with the infant whose temperament, social capabilities, appearance, and gender fit the parent’s expectations. If the infant does not meet these expectations, resolution of the parent’s disappointment can delay the attachment process. A list of infant behaviors affecting parental attachment that continues to be a classic comprehensive reference is presented in Table 17-1. A corresponding list of parental behaviors that affect infant attachment is presented in Table 17-2.

An important part of attachment is *acquaintance*. Parents use eye contact (Fig. 17-2), touching, talking, and exploring to become acquainted with their infant during the immediate postpartum period. Adoptive parents undergo the same process when they first meet their new child. During this

![Fig. 17-1 Hands. (Courtesy Marjorie Pyle, RNC, Lifecircle, Costa Mesa, CA.)](image-url)
TABLE 17-1
Infant Behaviors Affecting Parental Attachment

<table>
<thead>
<tr>
<th>FACILITATING BEHAVIORS</th>
<th>INHIBITING BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visually alert; eye-to-eye contact; tracking or following of parent's face</td>
<td>Sleepy; eyes closed most of the time; gaze aversion</td>
</tr>
<tr>
<td>Appealing facial appearance; randomness of body movements reflecting helplessness</td>
<td>Resemblance to person parent dislikes; hyperirritability or jerky body movements when touched</td>
</tr>
<tr>
<td>Smiles</td>
<td>Bland facial expression; infrequent smiles</td>
</tr>
<tr>
<td>Vocalization; crying only when hungry or wet</td>
<td>Crying for hours on end; colicky</td>
</tr>
<tr>
<td>Grasp reflex</td>
<td>Exaggerated motor reflex</td>
</tr>
<tr>
<td>Anticipatory approach behaviors for feedings; sucks well; feeds easily</td>
<td>Feeds poorly; regurgitates; vomits often</td>
</tr>
<tr>
<td>Enjoys being cuddled, held</td>
<td></td>
</tr>
<tr>
<td>Easily consolable</td>
<td></td>
</tr>
<tr>
<td>Activity and regularity somewhat predictable</td>
<td></td>
</tr>
<tr>
<td>Attention span sufficient to focus on parents</td>
<td></td>
</tr>
<tr>
<td>Differential crying, smiling, and vocalizing; recognizes and prefers parents</td>
<td></td>
</tr>
<tr>
<td>Approaches through locomotion</td>
<td></td>
</tr>
<tr>
<td>Clings to parent; puts arms around parent's neck</td>
<td></td>
</tr>
<tr>
<td>Lifts arms to parents in greeting</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 17-2
Parental Behaviors Affecting Infant Attachment

<table>
<thead>
<tr>
<th>FACILITATING BEHAVIORS</th>
<th>INHIBITING BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looks; gazes; takes in physical characteristics of infant; assumes en face position; eye contact</td>
<td>Turns away from infant; ignores infant's presence</td>
</tr>
<tr>
<td>Hovers; maintains proximity; directs attention to, points to infant</td>
<td>Avoids infant; does not seek proximity; refuses to hold infant when given opportunity</td>
</tr>
<tr>
<td>Identifies infant as unique individual</td>
<td></td>
</tr>
<tr>
<td>Claims infant as family member; names infant</td>
<td></td>
</tr>
<tr>
<td>Touches; progresses from fingertip to fingers to palms to encompassing contact</td>
<td></td>
</tr>
<tr>
<td>Smiles at infant</td>
<td></td>
</tr>
<tr>
<td>Talks to, coos, or sings to infant</td>
<td></td>
</tr>
<tr>
<td>Expresses pride in infant</td>
<td></td>
</tr>
<tr>
<td>Relates infant's behavior to familiar events</td>
<td></td>
</tr>
<tr>
<td>Assigns meaning to infant's actions and sensitively interprets infant's needs</td>
<td></td>
</tr>
<tr>
<td>Views infant's behaviors and appearance in positive light</td>
<td></td>
</tr>
</tbody>
</table>


Period families engage in the claiming process, which is the identification of the new baby (Fig. 17-3). The child is first identified in terms of “likeness” to other family members, then in terms of “differences,” and finally in terms of “uniqueness.” The unique newcomer is thus incorporated into the family. Mothers and fathers scrutinize their infant carefully and point out characteristics that the child shares with other family members and that are indicative of a relationship between them. The claiming process is revealed by maternal comments such as the following: “Russ held him close and said, ‘He’s the image of his father,’ but I found one part like me—his toes are shaped like mine.”

On the other hand, some mothers react negatively. They “claim” the infant in terms of the discomfort or pain the
baby causes. The mother interprets the infant’s normal responses as being negative toward her and reacts to her child with dislike or indifference. She does not hold the child close or touch the child to be comforting; for example, “The nurse put the baby into Marie’s arms. She promptly laid him across her knees and glanced up at the television. ‘Stay still until I finish watching; you’ve been enough trouble already.’”

Nursing interventions related to the promotion of parent-infant attachment are numerous and varied (Table 17-3). They can enhance positive parent-infant contacts by heightening parental awareness of an infant’s responses and ability to communicate. As the parent attempts to become competent and loving in that role, nurses can bolster the parent’s self-confidence and ego. Nurses are in prime positions to identify actual and potential problems and collaborate with other health care professionals who will provide care for the parents after discharge. Nursing considerations for fostering maternal-infant bonding among special populations may vary (Cultural Considerations box).

**Assessment of Attachment Behaviors**

One of the most important areas of assessment is careful observation of those behaviors thought to indicate the formation of emotional bonds between the newborn and family, especially the mother. Unlike physical assessment of the neonate, which has concrete guidelines to follow, assessment of parent-infant attachment requires much more skill in terms of observation and interviewing. Rooming-in of mother and infant and liberal visiting privileges for father, siblings, and grandparents facilitate recognition of behaviors that demonstrate positive or negative attachment. An excellent opportunity exists during feeding. Guidelines for assessment of attachment behaviors are presented in Box 17-1.

During pregnancy, and often even before conception occurs, parents develop an image of the “ideal” or “fantasy” infant. At birth the fantasy infant becomes the real infant. How closely the dream child resembles the real child influences the bonding process. Assessing such expectations during pregnancy and at the time of the infant’s birth allows identification of discrepancies in the parents’ view of the fantasy child versus the real child.

The labor process significantly affects the immediate attachment of mothers to their newborn infants. Factors such as a long labor, feeling tired or “drugged” after birth, and problems with breastfeeding can delay the development of initial positive feelings toward the newborn.

---

**Fig. 17-2** Mother and baby make eye contact in *en face* position. (Courtesy Michael S. Clement, MD, Mesa, AZ.)

**Fig. 17-3** Family members examine the new baby. They discuss how she resembles them and other family members. (Courtesy Marjorie Pyle, RNC, Lifecircle, Costa Mesa, CA.)

---

**Cultural Considerations**

**Fostering Bonding in Women of Varying Ethnic and Cultural Groups**

Childbearing practices and rituals of other cultures may not be congruent with standard practices associated with bonding in the Anglo-American culture. For example, Chinese families traditionally use extended family members to care for the newborn so that the mother can rest and recover, especially after a cesarean birth. Some Native-American, Asian, and Hispanic women do not initiate breastfeeding until their breast milk comes in. Haitian families do not name their babies until after the confinement month. Amount of eye contact varies among cultures, too. Yup’ik Eskimo mothers almost always position their babies so that eye contact can be made.

Nurses should become knowledgeable of the childbearing beliefs and practices of diverse cultural and ethnic groups. Because individual cultural variations exist within groups, nurses need to clarify with the patient and family members or friends what cultural norms the woman follows. Incorrect judgments may be made about mother-infant bonding if nurses do not practice culturally sensitive care.

<table>
<thead>
<tr>
<th>INTERVENTION LABEL AND DEFINITION</th>
<th>ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATTACHMENT PROMOTION</strong>&lt;br&gt;Facilitation of development of parent-infant relationship</td>
<td>Provide opportunity for parent(s) to see, hold, and examine newborn immediately after birth&lt;br&gt;Encourage parent(s) to hold infant close to body&lt;br&gt;Assist parent(s) to participate in infant care</td>
</tr>
<tr>
<td><strong>ENVIRONMENTAL MANAGEMENT: ATTACHMENT PROCESS</strong>&lt;br&gt;Manipulation of individuals’ surroundings to facilitate development of parent-infant relationship</td>
<td>Provide rooming-in in hospital&lt;br&gt;Create environment that fosters privacy&lt;br&gt;Individualize daily routine to meet parents’ needs&lt;br&gt; Permit father or significant other to sleep in room with mother&lt;br&gt; Develop policies that permit presence of significant others as much as desired</td>
</tr>
<tr>
<td><strong>FAMILY INTEGRITY PROMOTION: CHILDBEARING FAMILY</strong>&lt;br&gt;Facilitation of growth of individuals or families who are adding infant to family unit</td>
<td>Prepare parent(s) for expected role changes involved in becoming a parent&lt;br&gt;Prepare parent(s) for responsibilities of parenthood&lt;br&gt;Monitor effects of newborn on family structure&lt;br&gt;Reinforce positive parenting behaviors</td>
</tr>
<tr>
<td><strong>LACTATION COUNSELING</strong>&lt;br&gt;Use of interactive helping process to assist in maintenance of successful breastfeeding</td>
<td>Correct misconceptions, misinformation, and inaccuracies about breastfeeding&lt;br&gt;Evaluate parents’ understanding of infant’s feeding cues (e.g., rooting, sucking, alertness)&lt;br&gt;Determine frequency of feedings in relation to infant’s needs&lt;br&gt;Demonstrate breast massage and discuss its advantages to increasing milk supply</td>
</tr>
<tr>
<td><strong>PARENT EDUCATION: INFANT</strong>&lt;br&gt;Instruction on nurturing and physical care needed during first year of life</td>
<td>Determine parents’ knowledge, readiness, and ability to learn about infant care&lt;br&gt;Provide anticipatory guidance about developmental changes during first year of life&lt;br&gt;Teach parent(s) skills to care for newborn&lt;br&gt;Demonstrate ways in which parent(s) can stimulate infant’s development&lt;br&gt;Discuss infant’s capabilities for interaction&lt;br&gt;Demonstrate quieting techniques</td>
</tr>
<tr>
<td><strong>RISK IDENTIFICATION: CHILDBEARING FAMILY</strong>&lt;br&gt;Identification of individual or family likely to experience difficulties in parenting and assigning priorities to strategies to prevent parenting problems</td>
<td>Determine developmental stage of parent(s)&lt;br&gt;Review prenatal history for factors that predispose individuals or family to complications&lt;br&gt;Ascertain understanding of English or other language used in community&lt;br&gt;Monitor behavior that may indicate problem with attachment&lt;br&gt;Plan for risk-reduction activities in collaboration with individual or family</td>
</tr>
</tbody>
</table>

Early Contact

Early close contact may facilitate the attachment process between parent and child. This does not mean that a delay will inhibit this process (humans are too resilient for that), but additional psychologic energy may be needed to achieve the same effect. To date, no scientific evidence has demonstrated that immediate contact after birth is essential for the human parent-child relationship.

Parents who desire but are unable to have early contact with their newborn (e.g., the infant was transferred to the intensive care nursery) can be reassured that such contact is not essential for optimal parent-infant interactions. Otherwise, adopted infants would not form the usual affectionate ties with their parents. Nor does the mode of infant-mother contact after birth (skin-to-skin versus wrapped) appear to have any important effect. Nurses need to stress that the parent-infant relationship is a process that occurs over time.

Extended Contact

The provision of rooming-in facilities for the mother and her baby is common in family-centered care. The infant is transferred to the area from the transitional nursery (if the facility uses one) after showing satisfactory extraterine adjustment. The father is encouraged to participate in the care of the infant, and siblings and grandparents are also encouraged to visit and become acquainted with the infant. Whether the method of family-centered care is rooming-in, mother-baby or couplet care, or a family birth unit, mothers and their partners are considered equal and integral parts of the developing family. Partners are encouraged to take as active a role as they wish.

Extended contact with the infant should be available for all parents but especially for those at risk for parenting inadequacies, such as adolescents and low-income women. Any activity that optimizes family-centered care is worthy of serious consideration by postpartum nurses.

COMMUNICATION BETWEEN PARENT AND INFANT

The parent-infant relationship is strengthened through the use of sensual responses and abilities by both partners in the interaction. The nurse should keep in mind that there may be cultural variations in these interactive behaviors.

The Senses

Touch

Touch, or the tactile sense, is used extensively by parents and other caregivers as a means of becoming acquainted with the newborn. Many mothers reach out for their infants as soon as they are born and the cord is cut. Mothers lift their infants to their breasts, enfold them in their arms, and cradle them. Once the infant is close, they begin the exploration process with their fingertips, one of the most touch-sensitive areas of the body. Within a short time the caregiver uses the palm to caress the baby’s trunk and eventually enfolds the infant. Gentle stroking motions are used to soothe and quiet the infant; patting or gently rubbing the infant’s back is a comfort after feedings. Infants also pat the mother’s breast as they nurse. Both seem to enjoy sharing each other’s body warmth. There is a desire in parents to touch, pick up, and hold the infant (Fig. 17-4). They

Assessing Attachment Behavior

- When the infant is brought to the parents, do they reach out for the infant and call the infant by name? (Recognize that in some cultures, parents may not name the infant in the early newborn period.)
- Do the parents speak about the infant in terms of identification—whom the infant looks like; what appears special about their infant over other infants?
- When parents are holding the infant, what kind of body contact is there—do parents feel at ease in changing the infant’s position; are fingertips or whole hands used; are there parts of the body they avoid touching or parts of the body they investigate and scrutinize?
- When the infant is awake, what kinds of stimulation do the parents provide—do they talk to the infant, to each other, or to no one; how do they look at the infant—direct visual contact, avoidance of eye contact, or looking at other people or objects?
- How comfortable do the parents appear in terms of caring for the infant? Do they express any concern regarding their ability or disgust for certain activities, such as changing diapers?
- What type of affection do they demonstrate to the newborn, such as smiling, stroking, kissing, or rocking?
- If the infant is fussy, what kinds of comforting techniques do the parents use, such as rocking, swaddling, talking, or stroking?
comment on the softness of the baby’s skin and are aware of milia and rashes. As parents become increasingly sensitive to the infant’s like or dislike of different types of touch, they draw closer to the baby.

Variations in touching behaviors have been noted in mothers from different cultural groups (Galanti, 2003; Jiménez, 1995; Stewart & Jambunathan, 1996). For example, minimal touching and cuddling is a traditional Southeast Asian practice thought to protect the infant from evil spirits. Because of tradition and spiritual beliefs, women in India and Bali have practiced infant massage since ancient times (Miller, 2004; Zlotnick, 2000).

**Eye contact**

Interest in having eye contact with the baby has been demonstrated repeatedly by parents. Some mothers remark that once their babies have looked at them, they feel much closer to them. Parents spend much time getting their babies to open their eyes and look at them. In the United States, eye contact appears to cement the development of a trusting relationship and is an important factor in human relationships at all ages. In other cultures, eye contact may be perceived differently. For example, in Mexican culture, sustained direct eye contact is considered to be rude, immodest, and dangerous for some. This danger may arise from the mal ojo (evil eye), resulting from excessive admiration. Women and children are thought to be more susceptible to the mal ojo (D’Avanzo & Geissler, 2003).

As newborns become functionally able to sustain eye contact with their parents, time is spent in mutual gazing, often in the en face position, a position in which the parent’s face and the infant’s face are approximately 8 inches apart and on the same plane (see Fig. 17-2).

Nursing and medical practices that encourage this interaction should be implemented. Immediately after birth, for example, the infant can be positioned on the mother’s abdomen or breasts with the mother’s and the infant’s faces on the same plane so that they can easily make eye contact. Lights can be dimmed so that the infant’s eyes will open. Instillation of prophylactic antibiotic ointment in the infant’s eyes can be delayed until the infant and parents have had some time together in the first hour after birth.

**Voice**

The shared response of parents and infants to each other’s voices is also remarkable. Parents wait tensely for the first cry. Once that cry has reassured them of the baby’s health, they begin comforting behaviors. As the parents talk in high-pitched voices, the infant is alerted and turns toward them.

Infants respond to higher-pitched voices and can distinguish their mother’s voice from others soon after birth. Infants use their cries to signal hunger, pain, boredom, and tiredness. With experience, parents learn to distinguish among such cries.

**Odor**

Another behavior shared by parents and infants is a response to each other’s odor. Mothers comment on the smell of their babies when first born and have noted that each infant has a unique odor. Infants learn rapidly to distinguish the odor of their mother’s breast milk.

**Entrainment**

Newborns move in time with the structure of adult speech which is termed entrainment. They wave their arms, lift their heads, and kick their legs, seemingly “dancing in tune” to a parent’s voice. Culturally determined rhythms of speech are ingrained in the infant long before spoken language is used to communicate. This shared rhythm also gives the parent positive feedback and establishes a positive setting for effective communication.

**Biorhythmicity**

The fetus is in tune with the mother’s natural rhythms—biorhythmicity—such as heartbeats. After birth a crying infant may be soothed by being held in a position in which the mother’s heartbeat can be heard or by hearing a recording of a heartbeat. One of the newborn’s tasks is to establish a personal biorhythm. Parents can help in this process by giving consistent loving care and using their infant’s alert state to develop responsive behavior and thereby increase social interactions and opportunities for learning (Fig. 17-5). The more quickly parents become competent in child care activities, the more quickly their psychologic energy can be directed toward observing the communication cues the infant gives them.

**Reciprocity and Synchrony**

Reciprocity is a type of body movement or behavior that provides the observer with cues. The observer or receiver interprets those cues and responds to them. Reciprocity often
takes several weeks to develop with a new baby. For example, when the newborn fusses and cries, the mother responds by picking up and cradling the infant; the baby becomes quiet and alert and establishes eye contact; the mother verbalizes, sings, and coos while the baby maintains eye contact. The baby then averts the eyes and yawns; the mother decreases her active response (Fig. 17-6). If the parent continues to stimulate the infant, the baby may become fussy.

The term synchrony refers to the “fit” between the infant’s cues and the parent’s response. When parent and infant experience a synchronous interaction, it is mutually rewarding (Fig. 17-7). Parents need time to interpret the infant’s cues correctly. For example, after a certain time the infant develops a specific cry in response to different situations such as boredom, loneliness, hunger, and discomfort. The parent may need assistance in deciphering these cries, along with trial and error interventions, before synchrony develops.

**PARENTAL ROLE AFTER CHILDBIRTH**

Adaptation involves a stabilizing of tasks, a coming to terms with commitments. Parents demonstrate growing competence in child care activities and are more attuned to their infant’s behavior. Typically the period from the decision to conceive through the first months of having a child is termed the **transition to parenthood.**

**Transition to Parenthood**

Historically, the transition to parenthood was viewed as a crisis. The current perspective is that parenthood is a developmental transition (Tomlinson, 1996) rather than a major life crisis for the majority of families. The transition to parenthood is described as a time of disorder and disequilibrium, as well as satisfaction, for mothers and their partners (Rogan, Shmied, Barclay, Everitt, & Wyllie, 1997; Tomlinson, 1996).
Infant's response to the parental care and attention may be contributing in a unique way to the welfare of the infant. The competence. Breastfeeding makes mothers feel they are contributing appropriately to the infant's needs. Self-esteem grows with the cues given by the infant to indicate needs, and responding including care-giving activities, noting the communication now. I wouldn't change her for all the boys in the world.”

Then one day she was lying there and she turned her head over me, and we looked at each other a long time. It's okay and looked right at me. I felt a flooding of love for her come over me, and we looked at each other a long time. It's okay now. I wouldn't change her for all the boys in the world.”

To tell the truth, I felt like a monster not liking my child. she feedings and baths and things, but I couldn't feel excited. I know it is silly and irrational, but when they said, ‘She’s a lovely little girl,’ I was so disappointed and angry—yes, angry—I could hardly look at her. Oh, I looked after her okay, her feedings and baths and things, but I couldn’t feel excited. To tell the truth, I felt like a monster not liking my child. Then one day she was lying there and she turned her head and looked right at me. I felt a flooding of love for her come over me, and we looked at each other a long time. It's okay now. I wouldn’t change her for all the boys in the world.”

Parents need to reconcile the actual child with the fantasy and dream child. This means coming to terms with the infant’s physical appearance, sex, innate temperament, and physical status. If the real child differs greatly from the fantasy child, parents may delay acceptance of the child. In some instances they may never accept the child.

Some parents are startled by the normal appearance of the neonate—size, color, molding of the head, or bowed appearance of the legs. Many fathers have commented that they thought the odd shape of the infant’s head (molding) meant the infant would be mentally retarded.

Many parents know the sex of the infant before birth because of the use of ultrasound assessments; for those who do not have this information, disappointment over the baby's sex can take time to resolve. The parents may provide adequate physical care but find it difficult to be sincerely involved with the infant until this internal conflict has been resolved. As one mother remarked, “I really wanted a boy. I know it is silly and irrational, but when they said, ‘She’s a lovely little girl,’ I was so disappointed and angry—yes, angry—I could hardly look at her. Oh, I looked after her okay, her feedings and baths and things, but I couldn’t feel excited. To tell the truth, I felt like a monster not liking my child. Then one day she was lying there and she turned her head and looked right at me. I felt a flooding of love for her come over me, and we looked at each other a long time. It's okay now. I wouldn’t change her for all the boys in the world.”

Parents need to become adept in the care of the infant, including care-giving activities, noting the communication cues given by the infant to indicate needs, and responding appropriately to the infant’s needs. Self-esteem grows with competence. Breastfeeding makes mothers feel they are contributing in a unique way to the welfare of the infant. The infant’s response to the parental care and attention may be interpreted by the parent as a comment on the quality of that care. Infant behaviors that are interpreted by parents as positive responses to their care include being consoled easily, enjoying being cuddled, and making eye contact. Spitting up frequently after feedings, crying, and being unpredictable may be perceived as negative responses to parental care. Continuation of these infant responses that are viewed as negative by the parent can result in alienation of parent and infant to the detriment of the infant.

Parents, including advice by husbands, partners, wives, mothers, mothers-in-law, and professional workers, can either be seen as supportive or an indication of how inept these people have judged the new parents to be. Criticism, real or imagined, of the new parents’ ability to provide adequate physical care, nutrition, or social stimulation for the infant can prove to be devastating. By providing encouragement and praise for parenting efforts, nurses can bolster the new parents’ confidence.

Parents must establish a place for the newborn within the family group. Whether the infant is the first born or the last born, all family members must adjust their roles to accommodate the newcomer. The firstborn child needs support to accept a rival for parental affections. Children need help dealing with losing a favored position in the family hierarchy. The parents are expected to negotiate these changes.

**Maternal Adjustment**

Three phases are evident as the mother adjusts to her parental role (Table 17-4). These phases are characterized by dependent behavior, dependent-independent behavior, and independent behavior.

**Dependent phase**

During the first 24 to 48 hours after childbirth the mother’s dependency needs predominate. To the extent that these needs are met by others, the mother is able to divert her psychologic energy to her infant rather than to focus on herself. She needs “mothering” herself to “mother.” Rubin (1961) aptly described these few days as the taking-in phase, a time when nurturing and protective care are required by the new mother. In Rubin’s classic description the taking-in phase lasted 2 to 3 days. Later studies found that women move more rapidly through the taking-in phase (Ament, 1990; Wrasper, 1996). Evans, Dick, Shields, Shook, & Smith (1998), in a study of women giving birth vaginally, found that both taking-in and taking-hold were present on the evening of birth. For 24 hours after the birth, mature and apparently healthy women appear to suspend their involvement in everyday responsibilities and activities. They rely on others to satisfy their needs for comfort, rest, nourishment and closeness to their families and the newborn.

This dependent phase is a time of great excitement during which parents need to verbalize their experience of pregnancy and birth. Focusing on, analyzing, and accepting these experiences help the parents move on to the next phase. Some parents use staff members or other mothers as
an audience, whereas others are more comfortable talking with family and friends about the pregnancy and birth experience.

Because anxiety and preoccupation with her new role often narrow a mother’s perceptions, information may have to be repeated. The new mother may require reminders to rest or, conversely, to ambulate enough to promote recovery.

Physical discomfort can interfere with the mother’s need for rest and relaxation. The selective use of comfort measures and medication depends on the nurse. Many women hesitate to ask for medication, believing that any pain they experience is normal and to be expected; breastfeeding mothers may fear the effects of medication on the infant.

**Dependent-independent phase**

If the mother has received adequate nurturing in the first few hours or days, by the second or third day, her desire for independent action reasserts itself. In the dependent-independent phase, the mother alternates between a need for extensive nurturing and acceptance by others and the desire to “take charge” once again. She responds enthusiastically to opportunities to learn and practice baby care or, if she is an accomplished mother, to carry out or direct this care.

Rubin (1961) described this phase as the *taking-hold phase*, noting that it lasts approximately 10 days. Several studies (Evans et al., 1998; Martell, 1996; Wrasper, 1996) found that contemporary women exhibit taking-hold behaviors sooner than did the women in Rubin’s study; however, the peak and duration of the taking-hold phase were not determined. Evans and associates (1998) found that taking-hold behaviors began increasing between the evening of birth and the first morning despite high levels of sleep disturbance. Childbirth preparation classes, early contact with the newborn, rooming-in, and early discharge are some of the current obstetric practices that seem to enhance taking-hold behaviors (Martell; Wrasper).

Most mothers are discharged home during this dependent-independent phase. Once home, mothers must continue to cope with physical adaptations and psychologic adjustments. Most mothers identify fatigue as their major physical concern. This problem is acute during the early postpartum period and may persist as long as 19 months after birth (Troy, 2003). This fatigue affects various aspects of their lives such as their relationships with their partners and other family members and household responsibilities. Maternity nurses working in hospital postpartum units, birth centers, obstetric offices and home care, as well as pediatric nurses who come in contact with mothers during newborn well-baby checkups, are in excellent positions to screen new mothers for fatigue and to offer suggestions for coping with their feelings.

Other physical concerns of mothers are loss of weight or figure, pain from the episiotomy or cesarean incision, sexual relations, and hemorrhoids. Although many women express enjoyment during the early postpartum period, most describe the period as hectic and a time of great adjustment. Primiparas report feeling uncertain, trapped, and overwhelmed by fatigue and lack of experience in infant care. Although many multiparas describe their current experience as being better than that with previous births, primarily because of their comfort with caring for an infant, O’Reilly (2004) found that achieving a new balance was very important.

Prenatally and postnatally, nurses can discuss common postpartal concerns that mothers experience and provide anticipatory guidance on coping strategies, such as resting when the infant sleeps and planning with an extended family member or friend to do the housework for the first week or two after the baby is born. Once a mother is home, periodic

### TABLE 17-4

**Phases of Maternal Postpartum Adjustment**

<table>
<thead>
<tr>
<th>PHASE</th>
<th>CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent: Taking-in</td>
<td>• First 24 hr (range, 1 to 2 days)</td>
</tr>
<tr>
<td></td>
<td>• Focus: self and meeting of basic needs</td>
</tr>
<tr>
<td></td>
<td>• Reliance on others to meet needs for comfort, rest, closeness, and nourishment</td>
</tr>
<tr>
<td></td>
<td>• Excited and talkative</td>
</tr>
<tr>
<td></td>
<td>• Desire to review birth experience</td>
</tr>
<tr>
<td>Dependent-independent: Taking-hold</td>
<td>• Starts second or third day; lasts 10 days to several weeks</td>
</tr>
<tr>
<td></td>
<td>• Focus: care of baby and competent mothering</td>
</tr>
<tr>
<td></td>
<td>• Desire to take charge</td>
</tr>
<tr>
<td></td>
<td>• Still has need for nurturing and acceptance by others</td>
</tr>
<tr>
<td></td>
<td>• Eagerness to learn and practice—optimal period for teaching by nurses</td>
</tr>
<tr>
<td></td>
<td>• Handling of physical discomforts and emotional changes</td>
</tr>
<tr>
<td></td>
<td>• Possible experience with “blues”</td>
</tr>
<tr>
<td>Interdependent: Letting go</td>
<td>• Focus: forward movement of family as unit with interacting members</td>
</tr>
<tr>
<td></td>
<td>• Reassertion of relationship with partner</td>
</tr>
<tr>
<td></td>
<td>• Resumption of sexual intimacy</td>
</tr>
<tr>
<td></td>
<td>• Resolution of individual roles</td>
</tr>
</tbody>
</table>

phone calls from a nurse who cared for her in the birth setting can provide the mother with an opportunity to vent her concerns and get support and advice from “her” nurse. Nurses can set up Web pages on a hospital or clinic website to provide information for new mothers. These pages can include information about a variety of topics. This would enable nurses to cover a host of topics that might be of interest to parents the first postpartum year. Additionally, a link to other helpful sites might be provided (O'Reilly, 2004). First-time mothers inexperienced in child care, women whose careers had provided outside stimulation, women who lack friends or family members with whom to share delights and concerns, substance-abusing mothers, and adolescent mothers may need additional supportive counseling. When possible, postpartum home visits are included in the plan of care.

**Becoming a mother.** Mercer (2004) has suggested that the concept maternal role attainment, introduced by Rubin in 1961, be replaced with becoming a mother to signify the transformation and growth of the mother identity. Becoming a mother implies more than attaining a role. It includes learning new skills and increasing her confidence in herself as she meets new challenges in caring for her child(ren).

**Postpartum “blues.”** The “pink” period surrounding the first day or two after birth, characterized by heightened joy and feelings of well-being, is often followed by a “blue” period. Approximately 50% to 80% of women experience postpartum blues or “baby blues” (Beeber, 2002), which occur in women of all ethnic and racial groups (Campbell, 1992). When they have the blues, women are emotionally labile, often crying easily and for no apparent reason. This lability seems to peak around the fifth day and subside by the tenth day. Other symptoms of postpartum blues include depression, a let-down feeling, restlessness, fatigue, insomnia, headache, anxiety, sadness, and anger. Biochemical, psychological, social, and cultural factors have been explored as possible causes of the postpartum depressive state; however, the etiology remains unknown. Whatever the cause, the early postpartum period appears to be one of emotional and physical vulnerability for new mothers, who may be psychologically overwhelmed by the reality of parental responsibilities. The mother may feel deprived of the supportive care she received from family members and friends during pregnancy. Some mothers regret the loss of the mother–unborn child relationship and mourn its passing. Still others experience a let-down feeling when labor and birth are complete. Fatigue after childbirth is compounded by the around-the-clock demands of the new baby and can accentuate the feelings of depression. Postpartum depressive symptoms can have a negative effect on maternal role attainment (Fowles, 1998). To help mothers cope with postpartum blues, nurses can suggest various strategies (Patient Instructions for Self-Care box).

**Am I Blue?** (Johnson & Johnson, 1996), a self-administered questionnaire, can help mothers to assess their level of “blues” and to decide when to seek advice from their nurse, nurse-midwife, or physician (Fig. 17-8). Home visits and telephone follow-up calls by the nurse are important to assess the mother’s pattern of “blue” feelings and behavior over time.

Although the postpartum blues are usually mild and short lived, approximately half a million mothers in the United States each year experience a more severe syndrome termed postpartum depression (PPD) (Wisner, Parry, & Piontek, 2002). PPD symptoms can range from mild to severe, with women having “good days” and “bad days.” Goodman (2004) noted that there is a high incidence of PPD in fathers (1% to 26%). Screening should be done in both the mother and father for PPD. PPD can go undetected because new parents generally do not voluntarily admit to this kind of emotional distress out of embarrassment, guilt, or fear. Nurses need to include teaching about how to differentiate symptoms of the “blues” and PPD and urge parents to report depressive symptoms promptly if they occur (see Chapter 25).

**Interdependent phase**

In this phase, interdependent behavior reasserts itself, and the mother and her family move forward as a unit with interacting members. The relationship of the partners, although altered by the introduction of a baby, resumes many of its former characteristics. A primary need is to establish a lifestyle that includes but in some respects also excludes
Many new mothers feel anxious, sad, or angry about the changes in their lives after the birth of their new baby. It is perfectly normal to feel this way, but sometimes the feelings grow so strong that they make life difficult. This quiz lists many feelings and experiences of “blue” or depressed mothers. Mark how strong each of these feelings or experiences is for you, compared with what is normal for you. For example: Do you feel no anger [0]; mild (very little) anger [1]; moderate (some) anger [2]; or severe (very strong) anger [3] compared with the way you usually feel? Add up your total score when you are finished, and discuss the results with your health care provider.

### Am I Blue?

### Table: Am I Blue?

<table>
<thead>
<tr>
<th>Feeling/Experience</th>
<th>0 (Not at all)</th>
<th>1 (Mild)</th>
<th>2 (Moderate)</th>
<th>3 (Severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety attacks: periods of very strong fear, shortness of breath, rapid heartbeat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased or decreased appetite and/or weight gain or loss that doesn’t seem normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong feeling that you need to get away, need more time for your own interests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems in a relationship with a family member, lover, close friend, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crying spells</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less interest in your personal appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less motivation—less energy or interest in accomplishing goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue—feeling tired or exhausted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of harming yourself or your baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of your sense of humor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervousness, feeling tense or edgy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings of guilt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feelings of panic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling alone or lonely; without the support of others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling no love, or not enough love, for your baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling forgetful, distracted, absent-minded—having trouble concentrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hopelessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling irritable, bad-tempered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of sexual desire and/or pleasure in sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of self-respect or confidence—feeling like you don’t count or can’t do anything right</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling confused, uncertain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood swings—your moods and emotions change all the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessive thoughts—ideas or feelings you can’t stop from repeating in your mind</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odd or frightening thoughts—thoughts or images that scare you or that you can’t control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of suicide, feeling like you want to die</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling sad, unhappy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Score:

- **0 – 31 = MILD BLUES**
  - This will probably pass, but pay attention to your feelings and needs.

- **32 – 64 = MODERATE BLUES**
  - You may want to ask for help from a close friend or family member, or ask the advice of your health care provider.

- **65 – 98 = SEVERE BLUES**
  - You could be depressed; see your health care provider for a check-up and advice as soon as possible.

If you are afraid you might harm yourself or your baby—ask a health care provider you trust for help—you don’t have to be alone!

© Johnson & Johnson Consumer Products, Inc. 1996 All rights reserved.

**Fig. 17-8** “Am I Blue?” (Courtesy Johnson & Johnson Consumer Products, Skillman, NJ.)
the baby. The couple needs to share interests and activities that are adult in scope.

The couple may begin to engage in sexual intercourse during the second to fourth week after the baby is born. Some couples begin earlier, as soon as it can be accomplished without discomfort, depending on factors such as timing, amount of vaginal dryness, and breastfeeding status. Sexual intimacy enhances the adult aspect of the family, and the adult pair shares a closeness denied to other family members (see also Chapter 16). Changes in a woman’s sexuality after childbirth are related to hormonal shifts, increased breast size, uneasiness with a body that has yet to return to a prepregnant size, chronic fatigue related to sleep deprivation, and physical exhaustion (Bitzer & Adler, 2000). Many new fathers speak of the alienation experienced when they observe the intimate mother-infant relationship, and some are frank in expressing feelings of jealousy toward the infant. The resumption of sexual intimacy seems to bring the parents’ relationship back into focus. Before and after birth, nurses should review with new parents their plans for other pregnancies and their preferences for contraception.

The interdependent phase, termed the letting-go phase, is often stressful for the parental pair. Interests and needs often diverge during this time. Women and their partners must resolve the effects on their relationship of their individual roles related to childrearing, homemaking, and careers. Mothers (and partners) may take a more traditional role in an effort to adapt to parenthood; however, traditional women have reported more family disorganization months into parenthood. A special continuing effort has to be undertaken to strengthen the adult-adult relationship as a basis for the family unit.

Little is known about postpartum maternal adjustment in the lesbian couple. Relationship satisfaction in first-time lesbian parent couples appears related to egalitarianism, commitment, sexual compatibility, and communication skills, as well as the birth mother’s decision for insemination by an anonymous sperm donor (Osterwell, 1991; Reimann, 1999). Similar to heterosexual parent couples, most lesbian parent couples voice concern about having less time and energy for their relationship after the arrival of the baby (Gartrell et al., 1996). Both partners consider themselves to be equal parents of the baby who share actively in child rearing (Brewaeys, Devroey, Helmerhorst, Van Hall, & Ponjaert, 1995). A primary concern of co-mothers is the legal vulnerability of lesbian families confounded by their social invisibility (Reimann).

**Paternal Adjustment**

Research on paternal adjustment to parenthood indicates that fathers go through predictable phases during their transition to parenthood (Henderson & Brouse, 1991; St. John, Cameron, & McVeigh, 2005) (Table 17-5). During this period, fathers experience intense emotions. Many fathers acknowledge that their expectations were of limited value once they were immersed in the reality of parenthood. Feelings that often accompany this reality are sadness, ambivalence, jealousy, frustration at not being able to participate in breastfeeding, and an overwhelming desire to be more involved, most of which are different from the feelings mothers report. On the other hand, some fathers are pleasantly surprised at the ease and fun of parenting. In their transition to mastery, fathers take control and become more actively involved in the infant’s life.

First-time fathers perceive the first 4 to 10 weeks of parenthood in much the same way as mothers do, that is, as a period characterized by uncertainty, increased responsibility, disruption of sleep, and inability to control time needed to care for the infant and reestablish the marital dyad. Fathers express concern about decreased attention from their partners relative to their personal relationship, the mother’s lack of recognition of the father’s desire to participate in decision making for the infant, and limited time available to establish a relationship with their infants (Steinberg, Kruckman, & Steinberg, 2000). These concerns can precipitate feelings of jealousy of the infant. The father should discuss his individual concerns/needs with the mother/partner and become more involved with the infant. This can help alleviate feelings of jealousy in the father.

**TABLE 17-5**

_Transition to Fatherhood: A Three-Stage Process_

<table>
<thead>
<tr>
<th>STAGES</th>
<th>CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Expectations</td>
<td>Father has preconceptions about what life will be like after baby comes home</td>
</tr>
<tr>
<td>Stage 2: Reality</td>
<td>Father realizes that expectations are not always based on fact</td>
</tr>
<tr>
<td></td>
<td>Common feelings experienced are as follows:</td>
</tr>
<tr>
<td></td>
<td>Sadness</td>
</tr>
<tr>
<td></td>
<td>Ambivalence</td>
</tr>
<tr>
<td></td>
<td>Jealousy</td>
</tr>
<tr>
<td></td>
<td>Frustration</td>
</tr>
<tr>
<td></td>
<td>Overwhelming desire to be more involved</td>
</tr>
<tr>
<td>Stage 3: Transition to mastery</td>
<td>Some fathers are pleasantly surprised at ease and fun of parenting</td>
</tr>
<tr>
<td></td>
<td>Father makes conscious decision to take control and become more actively involved with infant</td>
</tr>
</tbody>
</table>
In U.S. culture, neonates have a powerful impact on their fathers, who become intensely involved with their babies (Fig. 17-9). The term used for the father’s absorption, preoccupation, and interest in the infant is engrossment. Characteristics of engrossment include some of the sensual responses relating to touch and eye contact that were discussed earlier and also the father’s keen awareness of features that he and the baby share that validate his claim to the infant. An outstanding response is one of strong attraction to the newborn. Fathers spend considerable time “communicating” with the infant and taking delight in the infant’s response to them. A sense of increased self-esteem and a sense of being proud, bigger, more mature, and older are all experienced by fathers after seeing their babies for the first time.

Fathers spend less time than mothers with infants, and fathers’ interactions with infants tend to be characterized by stimulating social play rather than caretaking. The subtle and more open differences in stimulation from two sources, mother and father, provide a wider social experience for the infant.

Fathers can benefit from nursing interventions during the postpartum period just as mothers can. Nurses can arrange to teach infant care when the father is present and provide anticipatory guidance for fathers about the transition to parenthood. Separate prenatal and parenting classes and parenting support groups for fathers can provide them with an opportunity to discuss their concerns and have some of their needs met. Postpartum phone calls and home visits by the nurse should include time for assessment of the father’s adjustment and needs.

**Father-infant relationship**

How parents respond to the birth of a child is influenced by various factors, including age, social networks, socioeconomic conditions, and personal aspirations for the future.

**FACTORS INFLUENCING PARENTAL RESPONSES**

How parents respond to the birth of a child is influenced by various factors, including age, social networks, socioeconomic conditions, and personal aspirations for the future.

**Age**

Maternal age has a definite effect on the outcome of pregnancy. The mother, fetus, and newborn are at highest risk when the mother is an adolescent or is more than 35 years old.

**Adolescent mother**

Although it is biologically possible for the adolescent female to become a parent, her egocentricity and concrete thinking interfere with her ability to parent effectively. The very young adolescent mother is inexperienced and unprepared to recognize the early signs of illness, potential danger, or household hazards. She may inadvertently neglect her child. The higher mortality rates among the infants of adolescent mothers are attributed to the inexperience, lack of knowledge, and immaturity of the mothers, causing them to be unable to recognize a problem and obtain the necessary resources to rectify the situation. Nevertheless, in most instances, with adequate support and developmentally appropriate teaching, adolescents can learn effective parenting skills.

The transition to parenthood may be difficult for adolescent parents. Coping with the developmental tasks of parenthood is often complicated by the unmet developmental needs and tasks of adolescence. Some young parents may experience difficulty accepting a changing self-image and adjusting to new roles related to the responsibilities of infant care. Other adolescent parents, however, may have higher self-concepts than their nonparenting peers (Alpers, 1998; Dalla & Gamble, 2000).

As adolescent parents move through the transition to parenthood, they may feel “different” from their peers, excluded from “fun” activities, and prematurely forced to enter an adult social role. The conflict between their own desires and the infant’s demands, in addition to the low tolerance for frustration that is typical of adolescence, further contributes to the normal psychosocial stress of childbirth. Lower maternal education is associated with less favorable maternal responses to distress and infant behavior (Dalla & Gamble, 2000; Diehl, 1997).

Maintaining a relationship with the baby’s father is beneficial for the teen mother and her infant. A close and satisfying relationship is positively correlated with maternal-fetal and maternal-infant attachment (Bloom, 1998). The involvement of the baby’s father is related to appropriate maternal behaviors and positive mother-infant relationship (Diehl, 1997).

Adolescent mothers provide warm and attentive physical care; however, they use less verbal interaction than do older parents, and adolescents tend to be less responsive and to interact less positively with their infants than older mothers. Interventions emphasizing verbal and nonverbal communication skills between mother and infant are important. Such intervention strategies must be concrete and specific because of the cognitive level of adolescents. Although some observers suggest that some adolescents may use more aggressive behaviors, a higher incidence of child abuse has not
been documented. In comparison with adult mothers, teenage mothers have a limited knowledge of child development. They tend to expect too much of their children too soon and often characterize their infants as being fussy. This limited knowledge may cause teenagers to respond to their infants inappropriately.

Many young mothers pattern their maternal role on what they themselves experienced. Therefore, nurses need to determine the type of support that people close to the young mother are able and prepared to give, as well as the kinds of community aid available to supplement this support. Many teen mothers can identify a source of social support, with the predominant source being their own mothers. Navajo adolescent mothers who had social support (emotional and instrumental) from their own mothers felt able to focus on both the adolescent and maternal roles without neglecting either role (Dalla & Gamble, 2000). Rural adolescent mothers who reported firm encouragement and resources to pursue their life aspirations had more resilient adjustments to parenthood than did adolescent mothers who did not have this type of support (Camarena et al., 1998).

The need for continued assessment of the new mother’s parenting abilities during this postbirth period is essential.

**Critical Thinking Exercise**

**Special Needs of Adolescent and Older First-Time Mothers**

Emily is 42 years old, an ICU nurse, and the mother of a 1-week-old daughter, who was born by cesarean birth. Emily is breastfeeding. When the nurse calls to check on the new family, Emily says, “I can’t seem to do anything right! I hurt, and I’m not getting any sleep. All the baby wants to do is cry, and so do I.”

Mia, age 16, lives at home with her mother and four siblings. She is bottle-feeding her new baby girl. Although the baby’s father says that he wants to be involved, he has only seen the baby once since she was born. During a routine phone call 72 hours after discharge, Mia tells the nurse that the baby is “waking up all the time and eating a whole bottle every 2 or 3 hours. She looks just like her father and acts like him, too!” Mia’s mother is helping her care for the baby but seems to want to take over and “do things her way.”

1. **Evidence**—Is there sufficient evidence to draw conclusions about the teaching and care needed by these new parents?
2. **Assumptions**—What assumptions can be made about the following issues:
   a. Relationship between maternal age and postpartum adjustment
   b. Need for support during the postnatal period
   c. Need for perinatal education
   d. Long-term prognosis for positive outcomes for both mothers
3. **Implications and priorities for nursing care** can be drawn at this time?
4. **Does the evidence objectively support your conclusion?**
5. **Are there alternative perspectives to your conclusion?**

In addition, continued support should also be provided by involving the grandparents and other family members, as well as through home visits and group sessions for discussion of infant care and parenting problems. Outreach programs concerned with self-care, parent-child interactions, child injuries, and failure to thrive, in addition to programs that provide prompt and effective community intervention, prevent more serious problems from occurring. As the adolescent performs her mothering role within the framework of her family, she may need to address dependency versus independency issues. The adolescent’s family members may also need help adapting to their new roles.

**Adolescent father**

The adolescent father and mother face immediate developmental crises, which include completing the developmental tasks of adolescence, making a transition to parenthood, and sometimes adapting to marriage. These transitions can be stressful. The nurse may initiate interaction with the adolescent father by asking him to be present when postpartum home visits are made and to accompany the mother and the baby to well-baby checkups at the clinic or pediatrician’s office. With the adolescent mother’s agreement the nurse may contact the father directly. Adolescent fathers need support to discuss their emotional responses to the pregnancy. The father’s feelings of guilt, powerlessness, or bravado should be recognized because of their negative consequences for both the parents and the child. Counseling of adolescent fathers must be reality oriented. Topics such as finances, child care, parenting skills, and the father’s role in the birth experience must be discussed. Teenage fathers also need to know about reproductive physiology and birth control options, as well as safer sex practices.

The adolescent father may continue to be involved in an ongoing relationship with the young mother and his baby. In many instances he also plays an important role in the decisions about child care and raising the child. He may need help to develop realistic perceptions of his role as “father to a child.” He is encouraged to use coping mechanisms that are not detrimental to his own, his partner’s, or his child’s well-being. The nurse enlists support systems, parents, and professional agencies on his behalf.

**Maternal age greater than 35 years**

Adjustment of older mothers to changes involved in becoming a parent and seeing themselves as competent is aided by support from their partners. Support from other family members and friends is also important for positive self-evaluation of parenting, a sense of well-being and satisfaction, and help in dealing with stress.

Changes in the sexual aspect of a relationship can be a stressor for new midlife parents. Mothers report that finding time and energy for a romantic rendezvous is more difficult. They attribute much of this to the reality of caring for an infant, but the decreasing libido that normally accompanies getting older also contributes.
Work and career issues are sources of conflict for older mothers (Reese & Harkless, 1996). Conflicts emerge over being disinterested, worrying about giving enough attention to work with the distractions of a new baby, and anticipating what it will be like to return to work. Child care is a major factor causing stress about work.

Another major issue for older mothers with careers is the perception of loss of control (Reese & Harkless, 1996). Mothers older than 35, when compared with younger mothers, are at a different stage in their careers, having attained high levels of education, career, and income. The loss of control experienced when going from the consistency of a work role to the inconsistency of the parent role comes as a surprise to many. Helping the older mother have realistic expectations of herself and of parenthood is essential.

New mothers who are also perimenopausal may find it hard to distinguish fatigue, loss of sleep, decreased libido, or other physiologic symptoms as the cause of the changes in their lives. Although many women view menopause as a natural stage of life, for midlife mothers this cessation of menstruation coincides with the state of parenthood. The changes of midlife and menopause can add more emotional and physical stress to older mothers’ lives because of the time- and energy-consuming aspects of raising a young child. Resources that older parents may find helpful are listed under Resources at the end of this chapter.

**Paternal age older than 35 years**

Older fathers describe their experience of midlife parenting as wonderful but not without drawbacks. What they see as positive aspects of parenthood in older years include increased love and commitment between the spouses, a reinforcement of why one married in the first place, a feeling of being complete, experiencing of “the child” again in oneself, more financial stability than in younger years, and more freedom to focus on parenting rather than on career. A common theme expressed is sharing: sharing joy, sharing in raising the child, sharing as a family. The main drawback of midlife parenting is the change that it makes in the relationships with their partners.

**Culture**

Cultural beliefs and practices are important determinants of parenting behaviors. Culture defines what is socially acceptable in terms of eye contact, touch, and space (Lipson, Dibble, & Minarik, 1996). Culture influences the interactions with the baby, as well as the parents’ or family’s caregiving style. For example, the provision for a period of rest and recuperation for the mother after birth is prominent in several cultures. Asian mothers must remain at home with the baby at least 30 days after birth and are not supposed to engage in household chores, including care of the baby. Many times the grandmother takes over the baby’s care immediately, even before discharge from the hospital (D’Avanzo & Geissler, 2003; Kim-Godwin, 2003). Likewise, Jordanian mothers have a 40-day lying-in after birth during which their mothers or sisters care for the baby (D’Avanzo & Geissler). Hispanics practice an intergenerational family ritual, *la cuarentena*. For 40 days after birth the mother is expected to recuperate and get acquainted with her infant. Traditionally, this involves many restrictions concerning food (e.g., spicy or cold foods, fish, pork, and citrus are avoided; tortillas and chicken soup are encouraged); exercise; and activities, including sexual intercourse. Abdominal binding is a traditional practice, and many women avoid tub bathing and washing their hair. Traditional Hispanic husbands do not expect to see their wives or infants until both have been cleaned and dressed after birth. *La cuarentena* incorporates individuals into the family, instills parental responsibility, and integrates the family during a critical life event (D’Avanzo & Geissler, Niska, Snyder, & Lia-Hoagberg, 1998).

Desire for and valuing of children is salient in all cultures. In Asian families, children are valued as a source of family strength and stability, are perceived as wealth, and are objects of parental love and affection. Infants almost always are given an affectionate “cradle” name that is used during the first years of life; for example, a Filipino girl might be called “Ling-Ling” and a boy “Bong-Bong.” See Table 2-2 for examples of some traditional cultural beliefs that may be important to parents from African-American, Asian, and Hispanic cultures.

Knowledge of cultural beliefs can help the nurse make more accurate assessments and diagnoses of observed parenting behaviors. For example, nurses may become concerned when they observe cultural practices that appear to reflect poor maternal-infant bonding. Algerian mothers may not unwrap and explore their infants as part of the acquaintance process because in Algeria, babies are wrapped tightly in swaddling clothes to protect them physically and psychologically (D’Avanzo & Geissler, 2003). The nurse may observe a Vietnamese woman who gives minimal care to her infant but refuses to cuddle or further interact with her baby. This apparent lack of interest in the newborn is this cultural group’s attempt to ward off “evil spirits” and actually reflects an intense love and concern for the infant (Galanti, 2003). An Asian mother might be criticized for almost immediately relinquishing the care of the infant to the grandmother and not even attempting to hold her baby when the infant is brought to her room. However, in Asian extended families, members show their support for a new mother’s rest and recuperation by assisting with the care of the baby. Contrary to the guidance given to mothers in the United States about “nipple confusion,” a mix of breastfeeding and bottle-feeding is standard practice for Japanese mothers. This is out of concern for the mother’s rest during the first 2 to 3 months and does not lead to any problems with lactation; breastfeeding is widespread and successful among Japanese women (Sharts-Hopko, 1995).

Cultural beliefs and values give perspective to the meaning of childbirth and parenting for a new mother. Nurses can provide an opportunity for a new mother to talk about her perception of the meaning of childbearing. In helping new
families adjust to parenthood, nurses must provide culturally sensitive care by following principles that enhance nursing practice within transcultural situations.

**Socioeconomic Conditions**

Socioeconomic conditions often determine access to available resources. Parents whose economic condition is made worse with the birth of each child and who are unable to use an effective method of fertility management may find child-birth complicated by concern for their own health and a sense of helplessness. Mothers who are single, separated, or divorced from their husbands or without a partner, family, and friends for whatever reason may view the birth of a child with dread. Serious financial problems may override any desire to mother the infant.

**Personal Aspirations**

For some women, parenthood interferes with or blocks their plans for personal freedom or advancement in their careers. Resentment concerning this loss may not have been resolved during the prenatal period, and if it remains unresolved, it will spill over into caregiving activities. This may result in indifference and neglect of the infant or in excessive concerns; the mother may set impossibly high standards for her own behavior or the child’s performance.

Nursing interventions include providing opportunities for mothers to express their feelings freely to an objective listener, to discuss measures to permit personal growth, and to learn about the care of their infant. Referring the woman to a support group of other mothers “in the same situation” may also be helpful.

Nurses also can be proactive in influencing changes in work policies related to maternity and paternity leaves, varying models of work sharing and “family friendly” work environments. Some corporations already structure their work sites to support new mothers (e.g., by providing on-site day care facilities and breastfeeding rooms).

**PARENTAL SENSORY IMPAIRMENT**

In the early dialogue between the parent and child, all senses—sight, hearing, touch, taste, and smell—are used by each to initiate and sustain the attachment process. A parent who has an impairment of one of the senses needs to maximize use of the remaining senses.

**Visually Impaired Parent**

Visual impairment alone does not seem to have a negative effect on mothers’ early parenting experiences. These mothers, just as sighted mothers, express the wonders of parenthood and encourage other visually impaired persons to become parents (Conley-Jung & Olkin, 2001). Mothers with disabilities tend to value the importance of performing parenting tasks in the perceived culturally usual way. Their maternal engagement also is facilitated by self-acceptance of their own unique differences in performing parenting tasks (Farber, 2000).

Although visually impaired mothers initially feel a pressure to conform to traditional, sighted ways of parenting, they soon adapt these ways and develop methods better suited to themselves (Conley-Jung & Olkin, 2001). Examples of activities that visually impaired mothers do differently include preparation of the infant’s nursery, clothes, and supplies. Mothers may put an entire clothing outfit together and hang it in the closet rather than keeping items separate in drawers. They might develop a labeling system for the infant’s clothing and put diapering, bathing, and other care supplies where they will be easy to locate with minimal searching (Conley-Jung & Olkin). A strength that visually impaired parents have is a heightened sensitivity to other sensory outputs. A visually impaired mother can tell when her infant is facing her because she notices the baby’s breath on her face.

One of the major difficulties that visually impaired parents experience is the skepticism, open or hidden, of health care professionals. Visually impaired people sense reluctance on the part of others to acknowledge that they have a right to be parents. All too often, nurses and doctors lack the experience to deal with the childbearing and childrearing needs of visually impaired mothers, as well as mothers with other disabilities (such as the hearing impaired, physically impaired, and mentally challenged). The best approach by the nurse is to assess the mother’s capabilities. From that basis, the nurse can make plans to assist the woman, often in much the same way as for a mother without impairments. Visually impaired mothers have made suggestions for providing care for women such as themselves during childbearing (Box 17-2). Such approaches by the nurse can help avoid a sense of increased vulnerability on the mother’s part.

Eye contact is considered important in U.S. culture. With a parent who is visually impaired, this critical factor in the parent-child attachment process is obviously missing. However, the blind parent, who may never have experienced this method of strengthening relationships, does not miss it. The infant will need other sensory input from that parent. An infant looking into the eyes of a mother who is blind may not be aware that the eyes are unseeing. Other people in the newborn’s environment can also participate in active eye-to-eye contact to supply this need. A problem may arise, however, if the visually impaired parent has an impassive facial expression. Her infant, after making repeated unsuccessful attempts to engage in face play with the mother, will abandon the behavior with her and intensify it with the father or other people in the household. Nurses can provide anticipatory guidance regarding this situation and help the mother learn to nod and smile while talking and cooing to the infant.

**Hearing-Impaired Parent**

The parent who has a hearing impairment faces another set of problems, particularly if the deafness dates from birth or early childhood. The mother and her partner are likely to
have established an independent household. A number of devices that transform sound into light flashes are now marketed and can be fitted into the infant’s room to permit immediate detection of crying. Even if the parent is not speech trained, vocalizing can serve as both a stimulus and a response to the infant’s early vocalizing. Deaf parents can provide additional vocal training by use of recordings and television so that from birth the child is aware of the full range of the human voice. Sign language is acquired readily by young children, and the first sign used is as varied as the first word.

Section 504 of the Rehabilitation Act of 1973 requires that hospitals and other institutions receiving funds from the U.S. Department of Health and Human Services use various communication techniques and resources with the deaf, including having staff members or certified interpreters who are proficient in sign language. For example, provision of written materials with demonstrations and having nurses stand where the parent can read their lips (if the parent practices lip reading) are two techniques that can be used. A creative approach is for the nursing unit to develop videotapes in which information on postpartum care, infant care, and parenting issues is signed by an interpreter and spoken by a nurse. A videotape in which a nurse signs while speaking would be ideal. With the advent of the Internet, many resources are available to the deaf parent (see Resources at the end of the chapter).

**SIBLING ADAPTATION**

Because the family is an interactive, open unit, the addition of a new family member affects everyone in the family. Siblings have to assume new positions within the family hierarchy. The older child’s goal is to maintain the lead position. Parents are faced with the task of caring for a new child while not neglecting the others. Parents need to distribute their attention in an equitable manner.

Reactions of siblings may result from temporary separation from the mother, changes in the mother’s or father’s behavior, or the siblings’ response to the infant’s coming home. Positive behavioral changes of siblings include interest in and concern for the baby and increased independence. Regression in toileting and sleep habits, aggression toward the baby, and increased seeking of attention and whining are examples of negative behaviors.

The parents’ attitudes toward the arrival of the baby can set the stage for the other children’s reactions (Fig. 17-10). Because the baby absorbs the time and attention of the important people in the other children’s lives, jealousy (sibling rivalry) is to be expected once the initial excitement of having a new baby in the home is over. However, sibling rivalry, or negative behaviors in siblings, may have been overemphasized in the past and exists for a comparatively short time. Developmentally appropriate behaviors in siblings are similar before and after the baby arrives. Firstborn children seem to continue their usual routines and are more pleased with newborns and more understanding of the baby’s need for care than the parents predict.

Parents, especially mothers, spend much time and energy promoting sibling acceptance of a new baby. Participating in sibling preparation classes makes a difference in the ability of mothers to cope with sibling behavior. Older children are actively involved in preparing for the infant, and this involvement intensifies after the birth of the child. Parents have to manage the feeling of guilt that the older children are being deprived of parental time and attention. Parents have to monitor the behavior of older children toward the

---

**BOX 17-2**

**Nursing Approaches for Working with Visually Impaired Parents**

1. Parents who are blind need oral teaching by health care providers because maternity information is not accessible to blind people.
2. A visually impaired parent needs an orientation to the hospital room that allows the parent to move about the room independently. For example, “Go to the left of the bed and trail the wall until you feel the first door. That is the bathroom.”
3. Parents who are blind need explanations of routines.
4. Parents who are blind need to feel devices (e.g., monitors, pelvic models) and to hear descriptions of the devices.
5. Visually impaired parents need “a chance to ask questions.”
6. Visually impaired parents need the opportunity to hold and touch the baby after birth.
7. Nurses need to demonstrate baby care by touch and to follow with, “Now show me how you would do it.”
8. Nurses need to give instructions such as, “I’m going to give you the baby. The head is to your left side.”

---

Fig. 17-10 Parents introducing “big” brother to infant daughter. (Courtesy Kim Molloy, Knoxville, IA.)
more vulnerable infant and divert aggressive behavior. Strategies that parents have used to facilitate acceptance of a new baby by siblings are presented in Box 17-3.

Siblings demonstrate acquaintance behaviors with the newborn. The acquaintance process depends on the information given to the child before the baby is born and on the child’s cognitive development level. The initial behaviors of siblings with the newborn include looking at the infant and touching the head (Fig. 17-11). The initial adjustment of older children to a newborn takes time, and children should be allowed to interact at their own pace rather than being forced to do so. To expect a young child to accept and love a rival for the parents’ affection assumes an unrealistic level of maturity. Sibling love grows as does other love—that is, by being with another person and sharing experiences (Fig. 17-12). The relationship that develops between siblings has been conceptualized as sibling attachment. This bond between siblings involves a secure base in which one child provides support for the other, is missed when absent, and is looked to for comfort and security.
well as exploration of roles that grandparents play in the family unit.

The 2000 Census reported that 2.4 million grandparents had primary responsibility for grandchildren who lived with them. Of this number, 39% had cared for their grandchildren more than 5 years (Simmons & Dye, 2003). Increasing numbers of grandparents are providing permanent care to their grandchildren as a result of divorce, substance abuse, child abuse and/or neglect, abandonment, teenage pregnancy, death, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), unemployment, incarceration, and/or mental health problems (Pebley & Rudkin, 1999). This emerging trend requires the nurse to evaluate the role of the grandparent in parenting the infant. Educational and financial considerations must be addressed and available support systems identified for these families (see Resources at the end of the chapter).

Fig. 17-11  First meeting. A, Sister touching new sibling with fingertip. B, Touching with whole hand. C, Smiles indicate acceptance. (Courtesy Sara Kossuth, Los Angeles, CA.)

Fig. 17-12  Grandmother with newborn and older sibling. Family contacts are important for newborn and siblings. (Courtesy Susan McGuire, Lexington, IL.)
Numerous changes occur during the first weeks of parenthood. Care management should be directed toward helping parents cope with infant care, role changes, altered lifestyle, and change in family structure resulting from the addition of a new baby. Parents may have inadequate or incorrect understanding of what to expect in the early postpartum weeks. Developing skill and confidence in caring for an infant can be especially anxiety provoking.

Nurses, especially those making postpartum visits to parents’ homes, are in a prime position to help new families. The nurse’s role becomes primarily one of teacher-supporter, focusing on enabling new parents to become capable of self-care and infant care and of meeting the needs of the family unit.

**Assessment and Nursing Diagnoses**

Assessment should include a psychosocial assessment focusing on parent-infant attachment, adjustment to the parental role, sibling adjustment, social support, and education needs, as well as mother’s and baby’s physical adaptation. Early home visits are an excellent opportunity for the nurse to assess beginnings of successful or harmful parenting behaviors and provide positive reinforcement for loving and nurturing behaviors with the infant. Parents who interact in inappropriate or abusive ways with the infant should be followed more closely, and an appropriate mental health practitioner or professional social worker should be notified.

Nursing diagnoses pertinent to transition to parenthood include the following:

- **Readiness for enhanced family coping related to**
  - positive attitude and realistic expectations for newborn and adapting to parenthood
  - nurturing behaviors with newborn
  - verbalizing positive factors in lifestyle change
- **Risk for impaired parenting related to**
  - lack of knowledge of infant care
  - feelings of incompetence or lack of confidence
  - unrealistic expectations of newborn or infant
  - fatigue from interrupted sleep
- **Parental role conflict related to**
  - role transition and role attainment
  - unwanted pregnancy
  - lack of resources to support parenting (e.g., no paid leave)
- **Risk for impaired parent-infant attachment related to**
  - difficult labor and birth
  - postpartum complications
  - neonatal complications or anomalies

**Expected Outcomes of Care**

A plan of care is formulated in collaboration with the family, incorporating their priorities and preferences, to meet their specific needs. Expected outcomes for effective transition to parenthood include that the parents will do the following:

- Demonstrate behaviors that reflect appreciation of sensory and behavioral capacities of the infant
- Verbalize increasing confidence and competence in feeding, diapering, dressing, and sensory stimulation of the infant
- Identify deviations from normal in the infant that should be brought to the immediate attention of the primary health care provider
- Relate effectively to the newborn’s siblings and grandparents

**Plan of Care and Interventions**

**Instructions for the first days at home**

Parents, especially first-time parents, must be helped to anticipate what the transition from hospital to home will be like. Anticipatory guidance can help prevent a shock of reality that might negate the parents’ joy or cause them undue stress. Even the simplest strategies can provide enormous support. Written information reinforcing education topics is helpful to provide to parents, as is a list of available community resources, both local and national (see Resources at end of chapter). Classes in the prenatal period or during the postpartum stay are helpful. Instructions for the first days at home should minimally include activities of daily living, dealing with visitors, and activity and rest.
EVIDENCE-BASED PRACTICE
Group Programs for Parents of Babies and Toddlers

BACKGROUND
• Emotional and behavioral problems in young children are predictive of later depression, substance abuse, poor work and marital outcomes, delinquency, and criminal behavior. These outcomes are frequently associated with harsh and inconsistent discipline, little positive parental involvement, and poor supervision. Parenting practices can account for 30% to 40% of the antisocial behavior in children. Praise, encouragement, and loving involvement with a child have a protective effect against later disruptive behavior and substance abuse. Social learning and attachment theories both claim that caregiving accounts for behavior problems in early childhood. Specific behavior problems include low sociability, poor peer relationships, anger, poor self-control, adolescent anxiety, and dissociation. Poor maternal-infant relationships result in cognitive deficits and poor achievement in school. Primary prevention is aimed at stopping the problem before it develops. Secondary prevention screens for early detection and treatment of the problem. Group parenting programs have a dual preventive role, since some of the children already demonstrate troubled behavior, even by 3 to 4 years of age. Group parenting programs have been found effective in improving behaviors in 3- to 10-year-olds and in reducing anxiety, depression, and poor self-esteem.

OBJECTIVES
• In the review authors wished to determine whether group-based parenting programs are effective at improving the emotional and behavioral outcomes of children, 0 to 3 years of age. The intervention was any group-based parenting program. The outcomes could be at least one measure of emotional and behavioral adjustment.

METHODS
Search Strategy
• The reviewers searched Cochrane, MEDLINE, EMBASE, Biological Abstracts, British Nursing Index, CINAHL, PsycINFO, Sociological Abstracts, Social Science Citation Index, ASSIA, National Research Registry, Dissertation Abstracts, ERIC, and bibliographies. Search keywords were parent, training, preschool, toddler, infant, baby, babies and combinations of these terms. Five randomized or quasi-randomized, controlled trials met the criteria, representing 417 parents. Some studies included both mother and father or grandparent/caretaker of the child, and some participants had more than one child in that age group. It is not clear how many children are represented in the studies. The trials, dated 1995 to 2000, were conducted in the United States and the United Kingdom.

Statistical Analyses
• Similar data were pooled. The treatment effect for each outcome was calculated and metaanalyzed, where appropriate. The authors accepted differences between groups that exceeded the 95% confidence interval to be significant.

FINDINGS
• The five studies measured many outcomes. Some measured child-only behaviors (e.g., parent and teacher questionnaires about behaviors such as inattentiveness, aggression, or excessive crying), while others addressed observable parent-child interactions (e.g., parent affect with child, physical negative behavior causing pain, praise, or critical statements). There was a significant improvement in the observed behavior of the children in the parenting group when compared with the controls. Parents’ report of children’s behavior trended in favor of the intervention group, but not to the level of significance. This was interesting, because parents frequently report behavior more favorably than independent observers. Follow-up data showed that improvement in the intervention group persisted, although it no longer reached the level of significance.

LIMITATIONS
• The reviewers had to compare a variety of scales to measure similar outcomes, which was a challenge. The limited number of studies, their small sizes, and some randomization problems (e.g., using volunteers and cluster data) limit generalizability. The dropout rate, 30% from two trials, was significant. In one of these studies, the dropouts were already using less harsh discipline. In another study, the dropout parents rated their children as significantly less problematic than the group that stayed. In prior studies, dropout rates were higher among subjects with more severe psychosocial problems and stress, and those who dropped out were more likely to be from a lower social class or an ethnic minority. Dropout rates introduce bias; therefore researchers have to account for the dropouts and evaluate the studies’ outcomes on “intention-to-treat” basis (i.e., their original randomized allocation), or the remaining data will be skewed.

CONCLUSIONS
• There is some support for group-based programs for parents of children up to 3 years of age, but conclusions regarding whether benefits are long term are equivocal. Anecdotally, parenting groups provide peer modeling for parents and networking that can provide support through future stages.

IMPLICATIONS FOR PRACTICE
• Two trials used 10-week Webster-Stratton programs, one called “Incredible Years,” and one used a videotape modeling program called “Parent and Child Series.” These programs might be useful in parenting programs. Parenting classes during pregnancy and in the postpartum period can help parents know what to expect and can prepare them for the challenges of parenting.

IMPLICATIONS FOR FURTHER RESEARCH
• The trials did not address the question of primary prevention of mental health problems, and further longer-term research is necessary. Early childhood parenting may provide greater benefits later. The researchers’ challenge is to capture those follow-up outcomes. Specific programs should be tested for effectiveness, so that the research is reproducible. Therapist credentials and training may account for variable results. (For more information, see “Parenting Groups for Teenage Parents,” the Evidence-Based Practice box in Chapter 3).

Activities of daily living. Given the demands of a newborn, the mother’s discomfort or fatigue associated with giving birth, and a busy homecoming day, even small details of daily life can become stressful. Such things as using disposable diapers, preparing frozen or microwave dinners during pregnancy, or getting takeout meals can decrease stress by eliminating at least one or two parental responsibilities during the first few days at home.

Planning for discharge soon after an infant feeding ensures that the couple will have adequate time to get home and relatively settled before the next feeding. Offering a sample carton of premixed bottles for the formula-fed infant prevents stress by eliminating at least one or two parental responsibilities during the first few days at home.

Visitors. New parents are often inadequately prepared for the reality of bringing a new infant home because they romanticize the homecoming. One mother stated, “By the time we drove an hour through traffic, my stitches were hurting and all I wanted was a warm sitz bath and some private time with Bill and the baby, in that order. Instead a carload of visitors pulled into the driveway as we were unbuckling the baby from his car seat. I thought I would surely cry.”

The nurse can help parents to explore ways, in advance, to assert their need to limit visitors. When family and friends ask what they can do to help, new parents can suggest they prepare and bring them a meal (which might be used immediately or frozen for later) or pick up items at the store. Parents can work out a signal for alerting the partner that the mother is getting tired or uncomfortable and needs the partner to invite the visitors to another room or to leave. Some mothers find that wearing a robe and not appearing ready for company leads visitors to stay a shorter time. A sign on the front door saying “Mother and baby resting—Please do not disturb” may be useful.

Activity and rest. Because mothers have reported fatigue to be a major problem during the first few weeks after giving birth, mothers need to be encouraged to limit their activities and be realistic about their level of fatigue. Activities should not be sustained for long periods of time. Family, friends, and neighbors can be solicited for support and help with meals, housecleaning, picking up other children, and so on. Rest periods throughout the day are important. Mothers can nap when the baby sleeps. Adequate nutrition is also important for postpartum recovery and in dealing with fatigue.

Infant care. Providing practical suggestions for infant care can help parents adjust to parenthood. Mothers and fathers want to feel capable and confident in the physical care of their infant. The nurse should assess each parent’s need for instruction on care such as bathing, clothing, and safety. (Guidelines/Guías box).

Infant bathing. The infant bath time provides a wonderful opportunity for parent-infant social interaction. Some fathers consider this their own special time with their babies. While bathing the baby, parents can talk to the infant, caress and cuddle the infant, and engage in arousal and imitation of facial expressions and smiling (Fig. 17-14).

Sponge baths are recommended until the infant’s umbilical cord falls off and the umbilicus is healed (see Chapter 19, Teaching Guidelines box on sponge bathing). At approximately 10 to 14 days, tub baths can be started (Box 17-4). Newborns do not need a bath every day. The diaper area and creases under the arms and neck need more attention.
Parents can pick a time for the bath that is easy for them and when the baby is awake, usually before a feeding.

An important consideration in skin cleansing is preservation of the skin’s acid mantle. The acid mantle is formed from the uppermost horny layer of the epidermis, sweat, superficial fat, metabolic products, and external substances such as amniotic fluid, microorganisms, and cosmetics. By 4 days of age, the newborn skin surface becomes more acidic, falling to within the bacteriostatic range (pH 5). Therefore only plain, warm water should be used in the early newborn period. Alkaline soaps (such as Ivory), oils, powders, and many lotions alter the acid mantle and provide a medium for bacterial growth (Lund et al., 2001). Powders are not recommended, because the infant can inhale powder.

**Infant clothing.** A simple rule of thumb for dressing infants is to dress them as the parents would dress themselves, adding or subtracting clothes and wraps for the infant as necessary. A shirt and diaper may be sufficient clothing for the young infant. A bonnet is needed to protect the scalp and to minimize heat loss if it is cool or to protect against sunburn and to shade the infant’s eyes if it is sunny and hot. Sunglasses for infants are available. Wrapping the infant snugly in a blanket maintains body temperature and promotes a feeling of security. Overdressing in warm temperatures can cause discomfort and prickly heat rash. Underdressing in cold weather also can cause discomfort; cheeks, fingers, and toes can easily become frostbitten.

Infants have sensitive skin; therefore new clothes should be washed before they are put on the infant. Baby clothes should be washed with a mild detergent and hot water. A double rinse usually removes traces of the potentially irritating cleansing agent or acid residue from urine or stool. If possible, the clothing and bed linens are dried in the sun to neutralize residue. Parents who use coin-operated machines in self-service laundries to wash and dry clothes may find it expensive or impossible to wash and rinse the baby’s clothes well.

Bedding requires frequent changing. The top of a plastic-coated mattress should be washed frequently, and the crib or bassinet should be dusted with a damp cloth. The infant’s toilet articles may be kept in a box, basket, or plastic carrier for convenience.

**Infant safety.** Providing for the safety of an infant is not a matter of common sense. There are many things new parents may not be aware of that are potential dangers to their infant (e.g., window blind cords near the crib or a parent throwing an infant in the air during play). Nurses should provide parents with concrete instructions on infant safety (Box 17-5).

**Anticipatory guidance regarding the newborn**

Anticipatory guidance helps prepare new parents for what to expect as their newborn grows and develops. Parents with realistic expectations of infant needs and behavior are
better prepared to adjust to the demands of a new baby and to parenthood itself (Guidelines/Guías box).

New parents can be overwhelmed by a large volume of information and become anxious. Anticipatory guidance should include the following: newborn sleep-wake cycles, interpretation of crying and quieting techniques, infant developmental milestones, sensory enrichment and infant stimulation, recognizing signs of illness, and well-baby follow-up and immunizations. Printed materials and audiotapes or videotapes for parents to take home are helpful. With more and more use of the Internet, parents may also be given a list of websites that might be accessed for information.

Development of day-night routines. Nurses can help prepare new parents for the fact that most newborns cannot tell the difference between night and day and must learn the rhythm of day-night routines. Nurses should provide basic suggestions for settling a newborn and for helping him or her develop a predictable routine. Examples of such suggestions include the following:

- In the late afternoon, bring the baby out to the center of family activity. Keep the baby there for the rest of the evening. If the baby falls asleep, let the baby do so in the infant seat or in someone’s arms. Save the crib or bassinet for nighttime sleep.
- Give the baby a bath right before bedtime. This soothes the baby and helps him or her expend energy.
- Feed the baby for the last evening time around 11 PM and put him or her to bed in the crib or bassinet.
- For nighttime feedings and diaper changes, keep a small night-light on to avoid turning on bright lights. Talk in soft whispers (if at all) and handle the baby gently and only as absolutely necessary to feed and diaper. Nighttime feedings should be all business and no play! Babies usually go back to sleep if the room is quiet and dark.

A predictable, stable routine gradually develops for most babies; however, some babies never develop one. New parents will find it easier if they are willing to be flexible and to give up some control during the early weeks.

Interpretation of crying and quieting techniques. Crying is an infant’s first social communication. Some babies cry more than others, but all babies cry. They cry to communicate that they are hungry, uncomfortable, wet, ill, or bored, and sometimes for no apparent reason at all. The longer parents are around their infants, the easier it becomes to interpret what a cry means. Many infants have a fussy period during the day, often in the late afternoon or early evening when everyone is naturally tired. Environmental tension adds to the length and intensity of crying spells. Babies also have periods of vigorous crying when no comforting can help. These periods of crying may last for long stretches until the infants seem to cry themselves to
**GENERAL ADVICE**

**CRYING**
- Babies cry when they are hungry; need to burp; have a wet diaper; feel cold, hot, tired, bored, or overstimulated; and (rarely) when they are sick or in pain. After a while you will learn the meaning of your baby’s different cries. Be careful not to feed him every time he cries, since overfeeding causes tummy aches. Check to see if he needs burping or a new diaper. It is not harmful to let a baby cry for short periods (5 to 10 minutes). This may be what he needs to fall asleep.

**SLEEPING**
- Most babies can sleep through most of the night without being fed, however, during the first 6 months, two to three feedings are required. Babies need to fall asleep and stay asleep. The nurse can teach parents a number of strategies that help quiet a fussy baby, prevent crying, and induce quiet at night. Emphasizing the individuality of the infant enhances the capacity of the family to offer their infant an optimally nurturing environment (Brazelton, 1995).

**DORMIR**
- La mayoría de los bebés puede dormir por casi toda la noche sin comer a los cuatro o cinco meses de edad. Un cuarto tranquilo y oscuro ayuda que su bebé duerma tranquility. Ambos usted y su bebé dormirán mejor y se despertarán menos si usted y el bebé duermen en camas separadas. Si se despierta el bebé durante la noche, déle la oportunidad de dormirse de nuevo. Pero si se queda despierto y tiene hambre, atiéndale. El bebé debe estar acostado sobre un costado o de espalda para su seguridad. Los bebés que duermen acostados de estómago con boca abajo tienen un riesgo más grande de muerte de cuna.

**ESCUPIR**
- La mayoría de los bebés escupe un poquito de la leche después de comer o de eructar. Esto es normal si su bebé está aumentando de peso. Es bueno poner a su bebé en una posición vertical y calmarlo por unos minutos después de darle de comer. Si parece que su bebé escupe mucha leche o si lo hace con mucha frecuencia, llévelo al doctor para verificar el peso del bebé.

Sleep. Possibly the infants are trying to discharge enough energy that they can settle themselves down. The nurse needs to reinforce for new parents that time and infant maturation will take care of these types of cries.

Crying because of colic is a common concern of new parents. Babies with colic cry in an inconsolable manner for several hours, pulling their legs up to their stomach, and passing large amounts of gas. No one really knows what colic is or why babies get it. Parents can be encouraged to contact their nurse-practitioner or pediatrician if they are concerned that their baby has colic.

Certain types of sensory stimulation can calm and quiet infants and help them get to sleep. Important characteristics of this sensory stimulation—whether tactile, vestibular, auditory, or visual—appear to be that the stimulation is mild, slow, and rhythmic, and consistently and regularly presented. Tactile stimulation can include warmth, patting, back rubbing, and covering the skin with textured cloth. Swaddling (Box 17-6) to keep arms and legs close to the body (as in utero) provides widespread and constant tactile stimulation and a sense of security. Vestibular stimulation is especially effective and can be accomplished by mild rhythmic movement such as rocking or by holding the infant upright, as on the parent’s shoulder.

The nurse can teach parents a number of strategies that help quiet a fussy baby, prevent crying, and induce quiet attention or sleep (Box 17-7).

**DEVELOPMENTAL MILESTONES.** Knowledge of infant growth and development helps parents have realistic expectations of what an infant can do. When parents understand and appreciate the limitations and developing abilities of their infant, adjustment to parenthood can go more smoothly. Emphasizing the individuality of the infant enhances the capacity of the family to offer their infant an optimally nurturing environment (Brazelton, 1995).

Brazelton (1995) suggests the concept of “touch-points” for intervention, that is, points at which a change in the system (baby, parent, and family) is brought about by the baby’s spurt in development (cognitive, motor, or emotional). Immediately before each spurt in development, there is a predictable short period of disorganization in the baby. Parents are likely to feel disorganized and stressed as well. Because these periods of disorganization are predictable, nurses can offer parents anticipatory guidance to help them understand
what happens with infant development and to prepare them for the subsequent spurts in development.

Two touch-points occur during the early postpartum-newborn period: one soon after birth and another at 2 to 3 weeks (Brazelton, 1995). In the hospital or at a home visit during the first week, the nurse can use Brazelton’s Neonatal Behavioral Assessment Scale (Brazelton & Nugent, 1996) to demonstrate to parents their baby’s amazing repertoire of abilities. In this way, parents begin to appreciate their baby’s individuality and become more sensitive to their baby’s behavioral cues. At 2 to 3 weeks the home care nurse or pediatric office nurse should assess for the regular end-of-the-day fussy period that most infants have between 3 and 12 weeks of age. Helpful topics to include in the anticipatory guidance are the normalcy and positive value of the fussy period, how to settle a fussy baby, and ways to help a baby develop a predictable schedule.

It is also helpful for nurses to provide parents with information on month-by-month infant growth and development. Written information that parents can refer to later is especially helpful. See Table 17-6 for a summary of infant growth and development during the first 2 to 3 months.

**Infant stimulation.** Interacting with their parents is an important way in which infants learn about themselves and their environment. Nurses can teach parents a variety of ways to stimulate their infant’s development and to enrich the infant’s learning environment. Home health nurses are in a prime position to evaluate the home environment

---

**BOX 17-6**

**How to Swaddle an Infant**

1. Fold down the top corner of the blanket. Position the infant on the blanket with the infant’s neck near the fold.
2. Bring the blanket around the infant’s right side and across the infant, tucking the corner under the left side.
3. Bring the bottom of the blanket up to the infant’s chest.
4. Bring the remaining corner of the blanket across the infant, tucking the corner under the infant’s right side.

The infant should be wrapped securely but not tightly; some room should be left for the infant to move.

---

**BOX 17-7**

**Infant Quieting Techniques**

- Many newborns feel insecure in the center of a large crib. They prefer a small, warm, soft space that reminds them of intrauterine life. Try a smaller bed, such as a bassinet, portable crib, buggy, or cradle, or use a rolled-up blanket to turn a corner of the big crib into a smaller place.
- Carry your baby in a frontpack or backpack.
- Swaddle your newborn snugly in a receiving blanket. Swaddling keeps your newborn’s arms and legs close to his or her body, similar to the intrauterine position. It makes the newborn feel more secure.
- Prewarm the crib sheets with a hot water bottle or heating pad that you remove before putting your baby to bed. Some babies startle when placed on a cold sheet.
- Some newborns need extra sucking to soothe themselves to sleep. Breastfeeding mothers may prefer to let their infant suckle at the breast as a soothing technique. Other mothers choose to use a pacifier. Stroke the pacifier against the roof of the baby’s mouth to encourage him or her to suck it during the first 2 weeks. Around 3 months of age, infants become able to consistently find and suck their thumbs as a way of self-consoling.
- A rhythmic, monotonous noise simulating the intrauterine sounds of your heartbeat and blood flow may help your infant settle down. Some parents have found that putting the baby in a portable crib beside the dishwasher or washing machine helps settle a fussy baby.
- Movement often helps quiet a baby. Take your baby for a ride in the car, or take your baby for an outing in a stroller or carriage. Rock your baby in a rocking chair or cradle.
- Place your baby on his or her stomach across your lap; pat and rub his or her back while gently bouncing your legs or swaying them from left to right.
- Babies enjoy close skin-to-skin contact. A combination of this and warm water often helps soothe a fussy baby. Fill your tub with warm water. Get in and let the baby lie on your chest so that the baby is immersed in the water up to his or her neck. Cuddle the baby close.
- Let your baby see your face. Talk to your baby in a soothing voice.
- Your baby may simply be bored. Bring him or her into the room where you and the rest of the family are. Change your baby’s position; many babies like to be upright, for example, by being held up on your shoulder.
<table>
<thead>
<tr>
<th>TABLE 17-6</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Growth and Development during Infancy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1 MONTH</strong></td>
<td><strong>2 MONTHS</strong></td>
</tr>
<tr>
<td><strong>PHYSICAL</strong></td>
<td>Posterior fontanel closed</td>
</tr>
<tr>
<td>Weight gain of 5 to 7.5 oz (150 to 210 g) weekly for first 6 mo</td>
<td></td>
</tr>
<tr>
<td>Height gain of 1 in (2.5 cm) monthly for first 6 mo</td>
<td></td>
</tr>
<tr>
<td>Head circumference increases by 0.6 in (1.5 cm) monthly for first 6 mo</td>
<td></td>
</tr>
<tr>
<td>Primitive reflexes present and strong</td>
<td></td>
</tr>
<tr>
<td>Doll’s eye reflex and dance reflex fading</td>
<td></td>
</tr>
<tr>
<td>Preferential nose breathing (most infants)</td>
<td></td>
</tr>
<tr>
<td><strong>GROSS MOTOR</strong></td>
<td>Assumes less flexed position when prone—hips flat, legs extended, arms flexed, head to side</td>
</tr>
<tr>
<td>Assumes flexed position with pelvis high but knees not under abdomen when prone (at birth, knees flexed under abdomen)†</td>
<td>Has only slight head lag when pulled to sitting position</td>
</tr>
<tr>
<td>Can turn head from side to side when prone, lifts head momentarily from bed</td>
<td>Assumes symmetric body positioning</td>
</tr>
<tr>
<td>Has marked head lag, especially when pulled from lying to sitting position</td>
<td>Able to raise head and shoulders from prone position to a 45- to 90-degree angle from table; bears weight on forearms</td>
</tr>
<tr>
<td>Holds head momentarily parallel and in midline when suspended in prone position</td>
<td>When held in standing position, able to bear slight fraction of weight on legs</td>
</tr>
<tr>
<td>Assumes asymmetric tonic neck reflex position when supine</td>
<td>Regards own hand</td>
</tr>
<tr>
<td>When held in standing position, body limp at knees and hips</td>
<td></td>
</tr>
<tr>
<td>In sitting position, back is uniformly rounded; absence of head control</td>
<td></td>
</tr>
<tr>
<td><strong>FINE MOTOR</strong></td>
<td>Hands often open</td>
</tr>
<tr>
<td>Hands predominantly closed</td>
<td>Grasp reflex absent</td>
</tr>
<tr>
<td>Grasp reflex strong</td>
<td>Hands kept loosely open</td>
</tr>
<tr>
<td>Hand clenches on contact with rattle</td>
<td>Clutches own hand; pulls at blanket and clothes</td>
</tr>
<tr>
<td><strong>SENSORY</strong></td>
<td></td>
</tr>
<tr>
<td>Able to fixate on moving object in range of 45 degrees when held at a distance of 8-10 in. Visual acuity approaches 20/100“</td>
<td></td>
</tr>
<tr>
<td>Follows light to midline</td>
<td></td>
</tr>
<tr>
<td>Quiets when hears a voice</td>
<td></td>
</tr>
<tr>
<td><strong>VOCALIZATION</strong></td>
<td></td>
</tr>
<tr>
<td>Cries to express displeasure</td>
<td>Squeals aloud to show pleasure†</td>
</tr>
<tr>
<td>Makes small throaty sounds</td>
<td>Coos, babbles, chuckles</td>
</tr>
<tr>
<td>Makes comfort sounds during feeding</td>
<td>Vocalizes when smiling</td>
</tr>
<tr>
<td><strong>SOCIALIZATION AND COGNITION</strong></td>
<td></td>
</tr>
<tr>
<td>Is in sensorimotor phase—stage I, use of reflexes (birth-1 mo), and stage II, primary circular reactions (1-4 mo)</td>
<td>Demonstrates social smile in response to various stimuli†</td>
</tr>
<tr>
<td>Watches parent’s face intently as she or he talks to infant</td>
<td></td>
</tr>
<tr>
<td>†Milestones that represent essential integrative aspects of development that lay the foundation for the achievement of more advanced skills.</td>
<td></td>
</tr>
<tr>
<td><em>Degree of visual acuity varies according to vision measurement procedure used.</em></td>
<td></td>
</tr>
</tbody>
</table>
Teaching Your Newborn

- Newborns learn things every day. You can teach your newborn by playing with him or her and giving your newborn toys that help him or her to learn.
- Talk to your baby a lot. Tell your baby what is going on in the room ("Listen to the dog barking!"). Label objects that you see or use ("Here’s the washcloth.") and describe things you are doing ("Let’s put the shirt over Kerry’s head!").
- Look at your baby’s face and make eye contact. Play face-making games: smile, stick out your tongue, open your eyes wide. As your baby gets older, he or she will try to imitate these facial expressions.
- Babies like music and rhythmic movement. Rock or swing your baby as you sing to him or her in a gentle voice.
- Acknowledge your baby’s attempts to “answer” your talking and singing. He or she will respond to you by looking in your direction, making eye contact, moving his or her arms and legs, and/or making sounds.
- Babies like bright colors and vivid contrasts. Show your baby pictures and objects that are black and white, bright primary colors (red, blue, yellow, green), and/or have large patterns. Keep colorful mobiles and toys where your baby can see them.
- Babies like to be held upright. Holding your newborn on your shoulder lets your baby look around his or her world and provides vestibular stimulation. Let your baby lift his or her head for a few seconds. Keep your hand ready to support your baby’s head.

Teaching Your 1- to 2-Month-Old Infant

At 1 to 2 months of age, your infant is gaining more control of his or her movements: the infant has more head control, and even may hold an object briefly in his or her hand. Your baby also is becoming more social. He or she demonstrates behaviors to engage you in interaction: smiling, cooing, making longer eye contact, and following you with his or her eyes.

During these months you can help your baby learn if you:
- Put your baby on his or her stomach on a blanket on the floor. Lie on your stomach facing your baby. Talk to your baby to get him or her to raise his or her head to see you.
- Roll your baby onto his or her back and play with your baby’s legs. Move the legs in a bicycle-riding motion. Try to get your baby to kick his or her legs.
- Play hand games, such as pat-a-cake, with your baby; kiss your baby’s fingers; place your baby’s hands on your face.
- Bring your baby’s hands in front of his or her eyes as you play; get your baby to look at his or her hands.
- Encourage your baby to watch and follow things with his or her eyes. Use a noise-making toy, such as a rattle or a chime, or a brightly colored object about 12 inches from his or her eyes; move it slowly to one side and then the other. Objects hanging from a play frame are good for your baby to watch while he or she is on his or her back or sitting in an infant seat.
- Continue to talk and sing a lot to your baby. Continue to tell your baby what you are doing with him or her and what is going on in the immediate environment.
- Keep your baby near you during times when the family usually is together, such as at mealtime. Infant seats, especially ones that bounce or rock, and infant swings are good to use at these times.
thereafter. These well-baby follow-up visits with a nurse-practitioner or pediatrician are important for the parents, as well as the infant. They provide a time for parents to have questions answered, to get reassurance about their adaptation to parenthood, and to receive anticipatory guidance for the ensuing weeks before the next well-baby visit.

The schedule for immunizations should be reviewed with parents (Table 17-8). Nurses should become familiar with this schedule and should provide written instructions to the parents about when and where to obtain immunizations. Immunization schedules change periodically and the nurse can update any information needed by checking with the website www.cdc.gov. An infant's ability to protect himself or herself against antigens by the formation of antibodies develops sequentially; therefore the infant must be developmentally capable of responding to these antibodies. This is the reason for planning sequential immunizations for infants.

**Recognizing signs of illness.** As well as explaining the need for well-baby follow-up visits, the nurse should discuss with parents the signs of illness in newborns (Box 17-10). Parents should be advised to call their nurse-practitioner or pediatrician immediately if they notice such signs and to ask about over-the-counter medications, such as Tylenol for infants, to keep at home (Plan of Care).

**Evaluation**

Evaluation is based on the expected outcomes of care. The plan is revised as needed based on the evaluation findings.

### TABLE 17-7

**Play during Infancy: Suggested Activities for Birth through 3 Months**

<table>
<thead>
<tr>
<th>AGE (MONTHS)</th>
<th>VISUAL STIMULATION</th>
<th>AUDITORY STIMULATION</th>
<th>TACTILE STIMULATION</th>
<th>KINETIC STIMULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-1</td>
<td>Look at infant at close range Hang bright, shiny object within 9 to 10 inches of infant's face and in midline</td>
<td>Talk to infant, sing in soft voice Play music box, radio, television Have ticking clock or metronome nearby</td>
<td>Hold, caress, cuddle Keep infant warm Infant may like to be swaddled</td>
<td>Rock infant, place in cradle Use carriage for walks</td>
</tr>
<tr>
<td>2-3</td>
<td>Hang mobiles with black-and-white contrast designs Provide bright objects Make room bright with pictures or mirrors on walls Take infant to various rooms while doing chores Place infant in infant seat for vertical view of environment</td>
<td>Talk to infant Include in family gatherings Expose to various environmental noises other than those of home Use rattles, wind chimes</td>
<td>Caress infant while bathing, at diaper change Comb hair with a soft brush</td>
<td>Use infant swing Take in car for rides Exercise body by moving extremities in swimming motion Use cradle gym</td>
</tr>
</tbody>
</table>


### TABLE 17-8

**Immunization Schedule—2005***

<table>
<thead>
<tr>
<th>IMMUNIZATION</th>
<th>AGE GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP (diphtheria, tetanus, acellular pertussis)</td>
<td>2, 4, 6 mo</td>
</tr>
<tr>
<td>Hib (<em>Haemophilus influenzae</em> b conjugate vaccine)</td>
<td>2, 4, 6 mo</td>
</tr>
<tr>
<td>IPV (inactivated polio vaccine—injectable)</td>
<td>2, 4, 6 to 18 mo</td>
</tr>
<tr>
<td>MMR (measles, mumps, rubella)</td>
<td>12 to 15 mo (12 mo if community outbreak)</td>
</tr>
<tr>
<td>HBIG (hepatitis B immunoglobulin—if mother is HBsAg positive)</td>
<td>Within 12 hours after birth</td>
</tr>
<tr>
<td>HBV (hepatitis B)</td>
<td>Before hospital discharge, 1 to 6 mo, 6 to 18 mo</td>
</tr>
<tr>
<td>PCV (<em>Pneumococcal</em> conjugate vaccine)</td>
<td>2, 4, 6, 12 to 18 mo</td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td>12 to 18 mo</td>
</tr>
<tr>
<td>Influenza (“flu shot”)</td>
<td>Yearly after 6 mo if at risk and/or in day care</td>
</tr>
<tr>
<td>Tuberculin skin test (not an immunization)</td>
<td>12 to 15 mo</td>
</tr>
</tbody>
</table>

*This is the schedule for the first 18 months. For the full schedule, go to www.cdc.gov.*
**BOX 17-10**  
**Signs of Illness to Report Immediately**

- Fever: temperature above 38°C (100.4°F) axillary (under arm for 3 to 4 minutes); also, a continual rise in temperature
- Hypothermia: temperature below 36.5°C (97.7°F) axillary
- Poor feeding or little interest in food: refusal to eat for two feedings in a row
- Vomiting: more than one episode of forceful vomiting or frequent vomiting (over a 6-hour period)
- Diarrhea: two consecutive green, watery stools (NOTE: Stools of breastfed infants are normally looser than stools of formula-fed infants. Diarrhea will leave a water ring around the stool, whereas breastfed stools will not.)
- Decreased bowel movement: less than two soiled diapers per day after 48 hours or less than three soiled diapers per day by the fifth day of life
- Decreased urination: no wet diapers for 18 to 24 hours or less than six to eight wet diapers per day
- Breathing difficulties: labored breathing with flared nostrils or absence of breathing for more than 15 seconds (NOTE: A newborn’s breathing is normally irregular and between 30 to 40 breaths per minute. Count the breaths for a full minute.)
- Cyanosis whether accompanying a feeding or not
- Lethargy: sleepiness, difficulty waking, or periods of sleep longer than 6 hours (Most newborns sleep for short periods, usually from 1 to 4 hours, and wake to be fed.)
- Inconsolable crying (attempts to quiet not effective) or continuous high-pitched cry
- Bleeding or purulent drainage from umbilical cord or circumcision
- Drainage developing in the eyes

---

**PLAN OF CARE**

**Home Care Follow-up: Transition to Parenthood**

**NURSING DIAGNOSIS**  
Deficient knowledge of infant care related to lack of care and lack of support

**Expected Outcomes**  
Infant care routines are adequate, and infant appears healthy.

**Nursing Interventions/Rationales**

- Observe infant care routines (bathing, diapering, feeding, play) to evaluate parental ease with care and adequacy of techniques.
- Observe infant appearance (height-weight ratio, head circumference, fontanelles, skin tone and turgor); assess infant’s vital signs, overall tone, reflexes, and age-appropriate developmental skills to evaluate for signs indicative of inadequate care.
- Explore available support systems for infant care to determine adequacy of existing system.
- Demonstrate troublesome care routines and have involved family members return demonstration to facilitate improvements in care.
- Provide ongoing follow-up as needed to ensure that identified potential and actual care deficits are addressed and resolved.

**NURSING DIAGNOSIS**  
Disturbed sleep patterns related to infant demands and environmental interruptions

**Expected Outcomes**  
Woman sleeps for uninterrupted periods and feels rested on waking.

**Nursing Interventions/Rationales**

- Discuss woman’s routine and specify things that interfere with sleep to determine scope of problem and direct interventions.
- Explore ways woman and significant others can make environment more conducive to sleep (e.g., privacy, darkness, quiet, back rubs, soothing music, warm milk); teach use of guided imagery and relaxation techniques to promote optimal conditions for sleep.
- Eliminate things or routines (e.g., caffeine, foods that induce heartburn, strenuous mental or physical activity) that may interfere with sleep.
- Advise family to limit visitors and activities to avoid further stress and fatigue.
- Have family plan specific times to care for the newborn to allow mother time to sleep; have mother learn to use infant nap time as a time for her to nap as well to replenish energy and decrease fatigue.

**NURSING DIAGNOSIS**  
Risk for impaired home maintenance related to addition of new family member, inadequate resources, or inadequate support systems

**Expected Outcome**  
Home exhibits signs of safe and functional environment.

**Nursing Interventions/Rationales**

- Observe the home environment (e.g., available living space and sleeping arrangements; adequacy of facilities for food preparation and storage, hygiene and toileting; overall state of repair; cleanliness; presence of safety hazards) to determine adequacy and effective use of resources.
- Explore arrangements for the newborn, such as sleeping space, care equipment and supplies (bathing, changing, feeding, transportation) to determine adequacy of resources.
- Explore who is responsible for cooking, cleaning, child care, and newborn care and determine whether the mother seems adequately rested to determine adequacy of support systems.
- Identify and arrange referrals to needed social agencies (e.g., Temporary Assistance for Needy Families [TANF], Women, Infants, and Children [WIC] program, food pantries) to address resource deficits (finances, supplies, equipment).

**NURSING DIAGNOSIS**  
Risk for interrupted family processes related to inclusion of new family member

**Expected Outcome**  
Infant is successfully incorporated into family structure.

**Nursing Interventions/Rationales**

- Explore with family the ways that the birth and neonate have changed family structure and function to evaluate functional and role adjustment.
- Explore family interaction with the newborn and note degree of bonding, evidence of sibling rivalry, and involvement in newborn care to evaluate acceptance of newest family member.
- Clarify identified misinformation and misperceptions to promote clear communication.
- Assist family to explore options for solutions to identified problems to promote effective problem resolution.
- Support family efforts as they move toward adjusting and incorporating the new member to reinforce new functions and roles.
- If needed, make referrals to appropriate social services or community agencies to ensure ongoing support and care.
Fathers, as well as mothers, can suffer from postpartum depression. Unfortunately, they are seldom identified and their needs are often overlooked. Interview a nurse working in a pediatric clinic or office. How often does the nurse identify symptoms of postpartum depression in fathers? Are the needs of fathers with postpartum depression similar to or different from those of depressed mothers? Is a father more likely to develop postpartum depression if his wife is also depressed? What support is available in the community for this group of men? What type of support would fathers with postpartum depression consider most helpful?

Key Points

- The birth of a child necessitates changes in the existing interactional structure of a family.
- Attachment is the process by which the parent and infant come to love and accept each other.
- Attachment is strengthened through the use of sensual responses or interactions by both partners in the parent-infant interaction.
- In adjusting to the parental role, the mother moves from a dependent state (taking in) to an interdependent state (letting go).
- Mothers may exhibit signs of postpartum blues (baby blues).
- Fathers experience emotions and adjustments during the transition to parenthood that are similar to, and also distinctly different from, those of mothers.

- Modulation of rhythm, modification of behavioral repertoires, and mutual responsivity facilitate infant-parent adjustment.
- Many factors influence adaptation to parenthood (e.g., age, culture, socioeconomic level, and expectations of what the child will be like).
- Parents face a number of tasks related to sibling adjustment that require creative parental interventions.
- Grandparents can have a positive influence on the postpartum family.
- Providing practical suggestions for infant care can help parents adjust to parenthood.
- Anticipatory guidance helps prepare new parents for what to expect as their newborn grows and develops.

Answer Guidelines to Critical Thinking Exercise

Special Needs of Adolescent and Older First-Time Mothers

1. Yes, both new mothers have stated what they perceive as their current priority needs. Nurses should address the needs identified by parents as important. Emily is an older mother who is used to being in control. She is upset about not being able to control the baby’s behavior (eating and sleeping routines). She may be experiencing postpartum blues and needs further assessment in this area. Physical concerns after a cesarean birth and breastfeeding should be explored also. The adolescent mother often needs additional family support in caring for her infant. However, there may be conflict between the mother and grandmother about what is best. Further exploration of the relationships between Mia and her mother and Mia and the baby’s father is indicated. An increased incidence of abuse may occur when one parent attributes negative characteristics of a partner to the infant. Mia has a knowledge deficit with regard to infant sleeping patterns and nutrition.

2. a. Both the adolescent and older woman may have difficulty adjusting to motherhood. Adolescents may have unrealistic expectations about newborn behavior and their relationship with the father of the infant. Intergenerational conflicts regarding childcare may also develop. The older mother may need to adjust to the loss of freedom and interruption in her career caused by the new baby.

b. Support from the father is very important to most new mothers. The adolescent mother may look to the father for both financial and emotional support. She may dream about becoming an “ideal” family. At this point, Mia is likely not receiving as much support as she desires from the baby’s father. On the surface, Emily appears to have more support. However, in an attempt to regain control by showing everyone she can “do it by herself,” she may refuse all offers of assistance.

c. Education about parenting, infant care, and realistic expectations for the postpartum period should have begun during pregnancy. Teaching should be individualized and continued in the hospital after delivery and beyond.

d. Adolescents who become parents have an increased likelihood of dropping out of school and are more likely to be single parents, have less income, and experience repeat pregnancies. With support from families and the community this outcome can be changed. With time, older mothers can adjust to the changes in their lives caused by the baby. Support from significant others and increasing competency can ease the transition to parenthood.

3. Priority nursing care at this time is to address Mia’s knowledge deficit regarding infant behavior and nutrition. Emily needs prompt attention because of her possible postpartum blues or depression. Additionally, Emily needs education about
breastfeeding and physical recovery after cesarean birth. More information on infant care and development should be given to both mothers.

4 Yes, there is evidence that meeting the new mother’s information needs regarding her care and care for the baby will increase her knowledge and skill and assist her in adapting to the role of mother. Adolescent and older women are two groups of new mothers that can especially benefit from individualized teaching.

5 Mia’s daughter might have an increased risk for child abuse because of her mother’s unrealistic expectations and negative feelings. Follow-up care should be arranged to assist Mia with her transition to parenthood. Mia might benefit from participating in a support group for adolescent mothers, where child care, infant development, and needs of the adolescent mother or parent are discussed. Including the grandmother in planning care for Mia and her baby will also be very important. Emily needs to be continually assessed at each visit for postpartum blues or depression.
References


